

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

X 2011

STATE NAME: Maryland

DUNS#: 135218621

I. AGENCY TO RECEIVE GRANT

AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Mental Hygiene Administration

STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building

CITY: Catonsville STATE: MD ZIP: 21228

TELEPHONE: 410-402-8473 FAX: 410-402-8309

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: John M. Colmers TITLE: Secretary

AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Office of the Secretary

CITY: Baltimore STATE: MD ZIP: 21201

TELEPHONE: 410-767-6505 FAX: 410-767-6489

III. STATE FISCAL YEAR

FROM: July 2010 TO: June 2011
Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

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AGENCY: Department of Health and Mental Hygiene

ORGANIZATIONAL UNIT: Mental Hygiene Administration

STREET ADDRESS: Spring Grove Hospital Center 55 Wade Avenue – Dix Building

CITY: Catonsville STATE: MD ZIP: 21228

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**COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT
FY 2011 APPLICATION**

September 2010

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The services and facilities of the Maryland State Department of Health and Mental Hygiene (DHMH) are operated on a non-discriminatory basis. This policy prohibits discrimination on the basis of race, color, sex or national origin and applies to the provisions of employment and granting of advantages, privileges and accommodations.

The Department, in compliance with the American with Disabilities Act, ensures that qualified individuals with disabilities are given an opportunity to participate in and benefit from DHMH services, programs, benefits, and employment opportunities.

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EXECUTIVE SUMMARY

During FY 2010, and moving into FY 2011, the Mental Hygiene Administration (MHA), the division of the State of Maryland Department of Health and Mental Hygiene (DHMH) that is responsible for overseeing the delivery of public mental health services in the state, was actively involved in numerous activities to refine, enhance, and improve management of the public mental health system (PMHS). MHA places a priority on the development of a system in which services meet individual needs across the lifespan and efforts are coordinated that support recovery and resiliency. Although faced with fiscal challenges, access to services is maintained and a consumer and family driven mental health system preserved and strengthened. Maryland operates the majority of its PMHS under a Medicaid 1115 Waiver. Specialty mental health care is carved out from physical care and is administered by MHA. The system is managed in collaboration with Core Service Agencies (CSAs), entities at the local level who, in collaboration with MHA, develop and manage a coordinated network of Maryland public mental health services.

An administrative services organization (ASO) assists MHA and the CSAs in the management of the system. The goal of the PMHS is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and consumer choice. On September 1, 2009 MHA transitioned to the new ASO, ValueOptions, Inc.

A detailed discussion of Maryland's significant highlights, new developments, and progress are included in Section I. Maryland's mental health system has seen many challenges as well as achievements over the past years. Community-based services are being further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will continue work to strengthen and support community-based services including diversion initiatives.

Maryland's Public Mental Health System's strengths were recognized with the selection of Maryland as one of the original seven states to receive a Mental Health Transformation State Incentive Grant of \$13.5 million over five years from SAMHSA. MHA has a solid record of innovation and flexibility in developing, implementing, and sustaining a PMHS that is a model for transformation. In FY 2010, the fifth and final year of the MHT-SIG, many of these Transformation projects include exploring and implementing sustainability. The State of Maryland continues to refine strategies to achieve organizational cultural change that will transform the delivery of mental health services and fully support recovery and resilience for consumers.

In Section II the service system's strengths, needs, and priorities for adults, children and adolescents are identified and analyzed. Review of this section provided both MHA staff and Joint Council members with the opportunity to engage in rich discussions about the strengths and weaknesses of the service system and to identify and reflect upon unmet service needs and gaps within the current system. This yielded further input into identification of state priorities and strategies included in the current State Mental Health Plan. MHA's FY 2011 priorities include:

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- Provision of consistent and seamless access to services and supports for both PMHS consumers and providers during transition to the new administrative services organization (ASO);
- Continuation of MHA's successful approach to the implementation of evidence-based practices and efforts to monitor fidelity;
- Continuation of statewide implementation of Wellness and Recovery Action Plan (WRAP) training to increase wellness and recovery orientation and utilize best practices within the consumer movement;
- Increased PMHS emphasis on implementation of new strategies to improve coordination of care between somatic and behavioral health providers and to research best practices to address the reduction of negative side effects of medication and prevention of obesity and morbidity for children in the child welfare system.
- Continued implementation of the *Maryland Child and Adolescent Mental Health Institute* in collaboration with the University of Maryland, the Johns Hopkins University, and the Maryland Coalition of Families for Children's Mental Health,
- Continued utilization of Web-based pharmacy data information sharing among mental health providers and with somatic care providers;
- Continued development of the Youth MOVE (Youth Motivating Others through Voices of Experience) program;
- Further implementation of the Medicaid Psychiatric Residential Treatment Facility waiver activities to reduce reliance on psychiatric residential treatment by supporting development of community-based, in-home, wraparound services for children and their families;
- Further development of an Outcomes Measurement System, focusing on analysis of PMHS data on outpatient registration and mandatory evaluation process; use of an interactive Website with aggregate information on consumers at the time of their most recent measurement available for public, provider, and government stakeholders; and change over time measured; and
- Efforts to promote Maryland's implementation of Health Care Reform.

Section III presents the five (5) Statutory Criteria. Separate adult and child and adolescent plans are presented. However, there is significant overlap between the two plans, as the overall system structure and many approaches to the service delivery are identical for both age groups. In Criterion five (5) – Management Systems, the discussion applies to both adult and child. Under each Criterion, mental health transformation efforts and activities in Maryland are described and then referenced to the specific goal(s) in the New Freedom Commission (NFC) Report. Finally, national and state goals, targets, and action plans are presented.

In previous years to foster the implementation of a consumer-driven, recovery and resilience oriented system, MHA followed SAMHSA's lead in adopting the goals and recommendations outlined in the 2003 New Freedom Commission Report: *Achieving the Promise: Transforming Mental Health Care in America*. To continue improvement in the delivery and financing of prevention, treatment and recovery support services, SAMHSA has identified 10 Strategic Initiatives to focus the Agency's efforts. Although references are made to the NFC throughout the document, for this year's planning cycle, MHA organized its FY 2011

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plan activities to be in concert with the SAMHSA's Strategic Initiatives. These 10 initiatives are as follows:

- Prevention of Substance Abuse and Mental Illness;
- Trauma and Justice;
- Military Families-Active, Guard, Reserve, and Veteran;
- Health Insurance Reform Implementation;
- Housing and Homelessness;
- Jobs and Economy;
- Health Information Technology for Behavioral Health Partners;
- Behavioral Health Workforce;
- Data and Outcomes; and
- Public Awareness and Support.

During the process of updating and drafting the goals, objectives, and strategies for the FY 2011 State Mental Health Plan, MHA staff, advocates, and all involved parties reviewed the goals and recommendations. Many of the key goals in the final report are fundamental concepts in the Mission, Vision, and Values of Maryland's PMHS. All are covered in some aspect of the State Plan, in our continuing efforts to promote recovery and resilience, implement evidence-based services, and cultivate a consumer and family driven system in which one's ethnic and cultural background is respected. Maryland takes pride in developing and delivering state-of-the-art mental health services and will continue to do so while remaining fiscally and clinically responsible.

MISSION

The Department of Health and Mental Hygiene's Office of Behavioral Health and Disabilities will develop an integrated process for planning, policy, and services to ensure a coordinated quality system of care is available to individuals with behavioral health conditions and developmental disabilities. The Mental Hygiene Administration will, through publicly funded services and supports, promote recovery, resiliency, and health for individuals who have emotional or psychiatric disorders.

THE VISION

The Vision of our public mental health system is drawn from fundamental core commitments:

- Coordinated, quality system of care
- A full range of services available
- Seamless linkages to services for the consumer delivered through a system of integrated care
- Recognition that co-occurring and co-morbid conditions are the norm
- Focus on treatment, behavioral health, support, recovery, and resilience
- Services developed in collaboration with culturally competent stakeholders in an environment that is culturally sensitive
- Improved health, wellness, and quality of life for consumers

VALUES

The values underpinning this system are:

(1) BASIC PERSONAL RIGHTS

Persons with psychiatric disabilities have the same rights and obligations as other citizens of the state. Consumers have the right to choice, to retain the fullest possible control over their own lives, and to have opportunities to be involved in their communities.

(2) RESPONSIVE SYSTEM

The Public Mental Health System must be responsive to the people it serves, coherently organized, and accessible to those individuals needing mental health care. Information must be readily available for individuals to enter and proceed through the system in a more appropriate and timely manner. The hospitals are one part of the community-based mental health system. The Public Mental Health System must collaborate with other public and private human health service systems in order to allow for continuity of care and facilitate support with all activities of life.

(3) EMPOWERMENT

Consumers, families, and advocates will be involved in decision-making processes, individually at the treatment level and collectively in the planning and operational aspects of the mental health system. An array of services and programs must be available to allow for consumer choice in obtaining and using necessary services. Relevant programs and services that recognize varying cultural, ethnic, and racial needs are imperative.

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(4) *FAMILY AND COMMUNITY SUPPORT*

We must provide families with the assistance they need in order to maintain or enhance the support they give to their family members. We will strive to provide services to persons within their communities with the availability of natural/family supports.

(5) *LEAST RESTRICTIVE SETTING*

An array of services will be available throughout the state to meet a variety of consumer needs. These services should be provided in the least restrictive, most normative, and most appropriate setting.

(6) *WORKING COLLABORATIVELY*

Collaborations with other agencies at the state and local level will be fostered so support to consumers is inclusive of all activities of life. This will promote a consistently appropriate level of mental health services.

(7) *EFFECTIVE MANAGEMENT AND ACCOUNTABILITY*

Accountability is essential to consistently provide an adequate level of mental health services. Essential management functions include monitoring and self-evaluation, responding rapidly to identified weaknesses in the system, adapting to changing needs, and improving technology. We must put the highest priority on measuring consumer satisfaction with the services they receive. Outcome measures will be a key component for evaluating program effectiveness.

(8) *LOCAL GOVERNANCE*

Local management of resources, resulting from the implementation of Core Service Agencies, will improve continuity of care, provide needed services in a timelier manner, improve the congruence of services and resources with needs, and increase economic efficiency due to the closer proximity of the service delivery level.

(9) *STAFF RESOURCES*

The presence of a competent and committed staff is essential for the provision of an acceptable level of mental health services. Staff must be provided with adequate support systems and incentives to enable them to focus their efforts on the individuals who receive care from them. Opportunities must be provided for skill enhancement training or retraining as changes in the service system take place.

(10) *COMMUNITY EDUCATION*

Early identification and prevention activities for risk groups of all ages, public education, and efforts that support families and communities must be incorporated into our service system. Increased acceptance and support for mental health services come from increased awareness and understanding of psychiatric disorders and treatment options.

FY 2011 SYSTEM GOALS

These MHA goals, objectives, and strategies are a result of the collaborative efforts related to the implementation of the federal Mental Health Transformation State Incentive Grant (MHT-SIG), existing interagency cooperation, and public and private partnerships. These alliances have been strengthened, and new partnerships formed to further build upon the infrastructure, to coordinate care and improve service systems. Mental health transformation efforts and activities have fostered the implementation of increased opportunities for public education; awareness; training of consumer, families, and mental health professionals; support of employment; self-directed care; and affordable housing options. Advancement will be effectively amplified through the support of Web-based technology that increases awareness and linkages to services; promotes wellness, prevention, and diversion activities; and enhances efforts in cultural competency, evidence-based and promising practices. These advancements are infused throughout the MHA State Mental Health Plan for children, adolescents, and adults. Recognizing the current fiscal environment, MHA strategies involve effective and efficient collaborations to identify and support sustainability of transformation gains that promote recovery, resiliency, and health-care reform.

- GOAL I: Increase Public Awareness and Support for Improved Health and Wellness**
- GOAL II: Promote a System of Integrated Care Where Prevention of Substance Abuse and Mental Illness are Common Practice Across the Life Span**
- GOAL III: Work Collaboratively to Reduce the Impact of Violence and Trauma for Individuals with Serious Mental Illness and Other Special Needs**
- GOAL IV: Provide a Coordinated Approach to Increase Employment and Promote Integration of Services and Training to Develop and Sustain an Effective Behavioral Health Workforce**
- GOAL V: Build Partnerships to Increase the Provision of Affordable Housing and Reduce Barriers to Access in Order to Prevent Homelessness for Individuals with Mental Illness**
- GOAL VI: Utilize Data and Health Information Technology to Evaluate, Monitor, and Improve Quality of Public Mental Health System Services and Outcomes**

PART B

**ADMINISTRATIVE REQUIREMENTS,
FISCAL PLANNING ASSUMPTIONS,
AND SPECIAL GUIDANCE**

DESIGNEE LETTER

FUNDING AGREEMENT – 1st PAGE

FUNDING AGREEMENT 2ND PAGE

FUNDING AGREEMENT 3RD PAGE

**FUNDING AGREEMENT – 4TH PAGE
SIGNATURE**

ATTACHMENT B
CERTIFICATIONS 1ST PAGE

ATTACHMENT B – 2ND PAGE

ATTACHMENT B

**CERTIFICATION – 3RD PAGE
SIGNATURE**

ATTACHMENT B

DISCLOSURE – 1st PAGE

ATTACHMENT B

DISCLOSURE – 2nd PAGE

ATTACHMENT C
ASSURANCES 1st PAGE

**ATTACHMENT C
ASSURANCES 2ND PAGE**

MR. Colmers SIGNS

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I (4) PUBLIC COMMENT ON THE STATE PLAN

Each year, official public notice of the State Mental Health Plan, Block Grant application, and Implementation Report is published in the Maryland Register for citizen review. The Register is published two times per month and provides information on state government activities. The notice in the Register provides information regarding the availability of the documents. Due dates for the application and the implementation report are noted. Comments are requested in writing. Any received prior to finalization of documents are considered and incorporated, as appropriate. Comments are also accepted after submission of documents to the federal government. The notice provides the name of a Mental Hygiene Administration contact person and phone number.

The opportunity to comment on the plan is provided at different stages in the state planning process. The most critical stages of this planning process involve the work of the Joint Council discussed in Part B, Section IV state Mental Health Planning Council. The development of the goals, objectives, and strategies for the annual state plan involves a series of meetings with active participation from key PMHS stakeholders including representatives of consumer and family advocacy organizations, mental health advocacy groups, advisory council for special needs populations, (such as the deaf and hard of hearing, traumatic brain injury), provider organizations, Core Service Agencies, and a wide range of groups, agencies, and individuals serving on the Joint Council. The annual Joint Council review and recommendation is summarized in the CMHS Block Grant review letter that is included as a part of this application.

During this public process, draft copies of the State Plan and key sections of the Block Grant application are distributed, through the Joint Council mailing and e-mail lists, for review and comment. The Planning Committee reviews the final draft of the State Plan and key Block Grant documents in two separate meetings with MHA staff.

Each year, following the adoption of the State Plan, the document is distributed through the Joint Council mailing list consisting of over 200 members, stakeholders, interested parties, Core Service Agencies, and local mental health advisory committee chairmen. Throughout the year, the MHA Division of Planning provides copies of the State Mental Health Plan to interested parties upon request. The review and comment on the annual Block Grant Implementation Report follows a somewhat similar process prior to the December submission deadline.

MHA's Division of Planning, in collaboration with the Division of Health Management Information Systems, places the approved State Plan on the Department of Health and Mental Hygiene-Mental Hygiene Administration Web site as a vehicle for notification of the availability and/or for wider distribution of the document. We expect this process to engender questions during the year, which will assist with the development of the Plan for the following year.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED). Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY X

Federal FY

State Expenditures for Mental Health Services

Calculated FY	Actual FY	Estimate/Actual FY
1994	2009	2010
<u>\$19,733,921</u>	<u>\$143,211,666</u>	<u>\$145,879,159</u>

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

1. The portion of the FY 2009 appropriation attributable to psychiatric medication is an estimate based on prior years' experience. The Medical Assistance appropriation (which includes funds for psychiatric medication) does not break down to the specific level of psychiatric medications.
2. The calculated FY 1994 rate reflects correction of clerical error in previous years applications. Compliance with the set-aside requirement has been continuously achieved.

III. MAINTENANCE OF EFFORT REPORT (MOE)

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY X Federal FY

State Expenditures for Mental Health

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Services		
Actual FY 2008	Actual FY 2009	Actual/Estimate FY 2010
<u>\$356,598,777</u>	<u>\$352,617,805</u>	<u>\$360,815,127</u>

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

The portion of the FY 2010 appropriation attributable to psychiatric medication is an estimate based on prior years' experience. The Medical Assistance appropriation (which includes funds for psychiatric medication) does not break down to the specific level of psychiatric medications.

**IV. MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/
PL 102-321 PLANNING COUNCIL REQUIREMENTS**

The Maryland Advisory Council on Mental Hygiene was created in 1976 to serve in an advisory and advocacy capacity in addressing mental health issues in Maryland. The Council was expanded in 1989 to comply with the composition requirements of Public Law (PL) 99-660 and subsequently PL 102-321. The Council is now designated as the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council and is often referred to as the Joint Council. Its membership is composed of consumers, family members of persons with psychiatric disorders, mental health professionals, representatives from various agencies that serve individuals with psychiatric disorders, and other citizens interested in the state's mental health delivery system. The Joint Council continues to participate in the planning and operation of the Public Mental Health System (PMHS), meeting monthly with the Mental Hygiene Administration (MHA) Executive Director and key agency staff.

The Joint Council operates under by-laws that set forth a committee structure to enhance its ability to monitor progress towards goals included in the Mental Hygiene Administration's (MHA) State Mental Health Plan and the federal Block Grant application. Committees of the Council include: the Interagency Forensic Services Committee (IFSC), the Planning Committee, the Legislative Committee, and the Membership Committee. These ongoing committees, among many other activities, develop the federal mental health block grant application, promote membership, follow legislative issues, and examine issues applicable to persons with serious mental illness incarcerated or at risk of incarceration in jails and detention centers.

The Planning Committee, which takes on responsibilities on a yearlong timeline, consists of Council representation of consumers, officers, agency members, rights advocacy organizations and members who represent interests across the lifespan. The Committee has been meeting as needed, not only to fulfill established duties of reviewing planning and implementation documents but also, to research and discuss ways to further impact MHA's future budget planning through focus on key mental health issues. The Planning Committee has advocated for alternatives to budget cuts to lessen the impact on the delivery of mental health care through correspondence with the Governor. At present, the Committee is exploring issues such as employment, as well as the availability of data presentations in this area.

Additionally, the Council promotes and facilitates linkages with Core Service Agency (CSA) boards and local mental health advisory committees as they monitor and evaluate publicly-funded mental health services for their local jurisdictions. The Maryland Association of CSAs (MACSA) is represented on the Council by a member who reports on statistics and highlights of the progress of the local CSAs.

The by-laws of the Joint Council are on the following pages.

**MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/
PL 102-321 PLANNING COUNCIL BY-LAWS**

PURPOSE:

Pursuant to the Annotated Code of Maryland, Health General, Title 10, Mental Hygiene Law, Subtitle 3, and Public Law 102-321, the State of Maryland has established the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council for the purpose of advising the Governor and other State and federal officials on the needs of citizens with mental illnesses and the ways in which the State can meet those needs. The Maryland Advisory Council on Mental Hygiene is mandated by State law to “be a strong advocate of a comprehensive, broad-based approach to the social, economic, and medical problems of mental hygiene.” Under federal law, the State Mental Health Planning Council is required “to advise, review, monitor and evaluate all aspects of the development and implementation of the State plan.” For purposes of implementing and coordinating the duties of the federal and State Councils, a Joint Council has been established and is herein referred to as “the Council.”

Article I: Duties

The Council shall:

1. Advocate for a comprehensive, broad-based approach to meet the social, economic, and medical needs of people with mental illnesses, as mandated by Health General 10-305.
2. Review plans provided to the Council by the Mental Hygiene Administration and submit to the State any recommendations of the Council for modifications to the plans, as mandated by PL 102-321.
3. Monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services, as mandated by PL 102-321.
4. Serve as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, as mandated by PL 102-321.
5. Submit an annual report of its activities to the Governor and, subject to Section 2-1312 of the State Government Article, to the General Assembly.

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6. Submit reports to the federal government, as mandated by PL 102-321.
7. Receive and review annual reports submitted by County Advisory Committees, as mandated by Health General 10-312, and,
8. Serve as a forum for the dissemination and sharing of information concerning the public mental health system between MHA staff, mental health advocates, Joint Council Members, including consumers, and providers of mental health services in Maryland, and other interested persons.
9. Serve as a linkage with other State agencies seeking collaboration for improved mental health services.

Article II: Membership

A. Composition:

1. The Maryland Advisory Council on Mental Hygiene consists of 18 members appointed by the Governor. Representatives include people from a broad range of agencies and groups that are concerned directly or indirectly with mental hygiene, e.g., courts, police, probation offices, clergy, labor, management, legal profession, medical profession, mental health associations, State and local government, private employee groups, local citizens groups, and major socio-economic and ethnic groups.
2. The PL 102-321 Planning Council consists of residents of Maryland, including representatives of (a) the principal State agencies (mental health, education, vocational rehabilitation, criminal justice, housing and social services); (b) public and private entities concerned with the need, planning, operation, funding and use of mental health services and related support services; (c) adults with serious mental illness who are receiving (or who have received) mental health services; (d) family members of adults who are receiving (or who have received) mental health services; and (e) family members of children with serious emotional disturbances, who are receiving (or who have received) mental health services. Members also shall include representatives from local Mental Health Advisory Committees.

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3. A minimum of 50 percent of the total membership of the Council will be individuals who are not State employees or providers of mental health services. The Council shall strive to assure the majority of members represent present and former recipients of mental health services and their families, and, further, that the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council. The membership of the Council shall be in compliance with PL 102-321, all subsequent amendments, and applicable State laws.

B. Term of Membership:

1. Members of the Maryland Advisory Council on Mental Hygiene are appointed by the Governor to serve three-year terms. A member may be appointed to serve a shorter term when serving the remaining term of a seat vacant due to a resignation. A member who is appointed after a term has begun serves only for the rest of the term and until a successor is appointed and qualifies. At the end of a term, the member continues to serve until a successor is appointed and qualifies.
2. Members of the PL 102-321 Planning Council are appointed by the Director of the Mental Hygiene Administration for three-year terms. Agency/organization representatives of PL 102-321 are chosen by their respective agencies. The selected representatives remain as members of the Council until such time that they leave the agency and/or position or the agency itself selects a replacement for them.
3. Terms of all Council members are staggered so that one third of members' terms end each year.

C. Removal:

1. Members of the Maryland Advisory Council on Mental Hygiene are subject to Article 41, Section 1-203 of the Annotated Code of Maryland that states: "Any member of any State Board or Commission appointed by the Governor who shall fail to attend 50 percent of the meetings of the Board or Commission of which he is a member during any period of twelve consecutive months shall be considered to have resigned and the Chairman of said Board or Commission shall forward or cause to be forwarded to the Governor, not later than January 15 of the year following such

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nonattendance with the statement of such nonattendance, and the Governor shall thereupon appoint his successor for the remainder of the term. If the member has been unable to attend meetings as required by this section for reasons satisfactory to the Governor, the Governor may waive such resignation if such reasons are made public.”

2. Non agency/organization representatives of the PL 102-321 Planning Council who fail to attend 50 percent of meetings during any period of 12 consecutive months shall be considered to have resigned. The Chairperson shall forward or cause to be forwarded to the Director of the Mental Hygiene Administration a statement of nonattendance and a request for removal. If the member has been unable to attend meetings as required for reasons satisfactory to the Director, the Director may waive such resignation if such reasons are made public.
3. In the event an agency/organization representative on the PL 102-321 Planning Council fails to attend 50 percent of the meetings during any period of 12 consecutive months, the Chairperson shall recommend to the head of the agency/organization that the member be replaced. If the agency member has been unable to attend meetings as required for reasons satisfactory to the Director, the Director may waive such resignation if such reasons are made public.

D. Travel Allowance:

Council members whose transportation costs are not reimbursed by an agency, group or organization, and who need financial assistance in order to attend a Council meeting and/or when officially representing the Council at other meetings, are eligible for reimbursement by the Mental Hygiene Administration. Travel expenses shall be consistent with the Standard State Travel Regulations and are dependent upon resource availability. Council members are responsible for completing all expense reporting forms in a timely manner, and submitting appropriate accompanying documentation as required.

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Article III: Meetings, Agenda, Voting, Official Records

A. Meetings

The Council shall meet at the times and places that it determines. There shall be at least six meetings per year. Special meetings of the Council shall be authorized by the Executive Committee, at the request of two-thirds of the total Councils' voting members. Ad hoc and standing subcommittee meetings may be convened whenever necessary. If necessary, the Executive Committee or any other committee can meet and converse by telephone when it is not feasible to convene and an immediate decision is required. Decisions reached by telephone shall be recorded as meeting minutes for that date and considered official meeting minutes.

B. Agenda

Any member of the Council may submit to the Chairperson an item for the agenda. Whenever possible, this shall occur at least two weeks before the scheduled date of the meeting. The agenda for regular meetings of the Council shall be distributed to members during the week prior to the scheduled meetings. At the beginning of each meeting of the Council, the Chairperson shall entertain motions for additions or changes in the agenda.

C. Voting

A quorum for any meeting of the Council shall consist of a simple majority of its members present at that meeting. Robert's Rules of Order govern the voting procedures. Only members of the Council are eligible to vote. Members with any conflicts of interest are expected to make a declaratory statement on same and refrain from voting on the issue(s). No member of the Council may cast a vote on any matter that would provide direct financial benefit to that member or otherwise give the appearance of a conflict of interest.

D. Official Record

The minutes of the Council meeting shall be the official record of the Council. The minutes shall be distributed to all members of the Council and to the Director of the Mental Hygiene Administration within a three-week period

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

following a meeting. After final adoption, minutes will be mailed to all local Mental Health Advisory Committees. All minutes, recommendations, and other materials will be kept on file by the Mental Hygiene Administration. Minutes may be distributed to interested members of the public, providing any and all confidential information has been excised.

Article IV: Support Services

The Mental Hygiene Administration shall provide secretarial, consultant, and other staff services needed by the Council within resource availability. The support staff shall be responsible for obtaining meeting facilities, recording of minutes, disseminating meeting notices, agenda, minutes, reports, etc.

Article V: Officers

A. Chairperson

The Chairperson shall be elected from among the appointed membership of the Maryland Advisory Council on Mental Hygiene. The Chairperson shall serve for two years and may be reelected for no more than two consecutive terms. Elections shall be held annually in June and the term shall begin on July 1 through June 30.

The Chairperson shall be responsible for:

1. Calling and presiding over all joint meetings of the Council;
2. Coordinating the activities of the Council, including preparation of the required State and federal reports;
3. Preparing the agenda for the meeting of the Council;
4. Appointing the Chairpersons and members of the Nominating Committee and the Chairpersons of ad hoc subcommittees;

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5. Serving as ex-officio on standing and ad hoc committees, except for the Nominating Committee; and,
6. Representing the opinion of the Council to the public.

B. Vice Chairperson

The Vice Chairperson shall be elected from among the appointed membership of the Maryland Advisory Council. The Vice Chairperson shall be responsible for the Chairperson's duties in the absence of the Chairperson. The Vice Chairperson shall be elected in June and the term shall begin on July 1 through June 30. The Vice Chairperson shall serve for two years and may be reelected for no more than two consecutive terms.

C. PL 102-321 Coordinators

Two persons shall be elected from the PL 102-321 membership as PL 102-321 Coordinators. The Coordinators shall serve for two years and may be reelected for no more than two consecutive terms. The Coordinators shall be responsible for assuring tasks and issues related to the Council's role and implementation of the State plan are completed. One Coordinator should be a recipient or former recipient of mental health services or a relative of such an individual.

Article VI: Committees

A. Nominating Committee

The Nominating Committee Chairperson and four other members shall be appointed by the Chairperson. Members shall be selected equally from both Councils. The Nominating Chairperson is responsible for convening the Nominating Committee, soliciting nominations and submitting the Committee's report to the Council in May for elections to be held in June.

B. Executive Committee

The Executive Committee shall be composed of the Chairperson, Vice Chairperson, the PL 102-321 Coordinators and Committee and Ad Hoc Committee Chairpersons. The Executive Committee shall meet on an ad hoc basis. Minutes shall be recorded for all Executive Committee meetings. The Executive Committee responsibilities include, but are not limited to, preparing, reviewing or approving testimony or other public presentations/documents/reports submitted on behalf of the Council when sufficient time does not permit review and approval of the entire Council and timing is of critical importance, etc.

C. Interagency Forensic Services Committee

This Committee shall advise, review, monitor and evaluate the development and implementation of the State plan applicable to persons with serious mental illness incarcerated or at risk of incarceration in jails and detention centers. This Committee may invite others outside of appointed Council members to consult and participate in the activities of this Committee. The Chairperson of this Committee shall be elected by the members of the Committee, with the approval of the Council Chairperson, for a two year renewable term.

D. Local Mental Health Advisory Committee

The duties of this committee include promoting and facilitating linkages with local mental health advisory committees. The Committee may assist in developing specific training programs pertaining to mental health issues and the roles of the committees in local mental health systems. This Committee may invite others outside of appointed Council members to consult and participate in the activities of this Committee. The Chairperson of this Committee shall be elected by the members of the Committee, with the approval of the Council Chairperson, for a two year renewable term.

E. Legislative Committee

The duties of this committee include review and promotion of legislation that impacts on the purpose and responsibilities of the Council.

F. Planning Committee

The duties of this committee include assisting in the plan development, review and final recommendation of the State Mental Health and Federal Mental Health Block Grant Plans.

G. Annual Report Committee

The duties of this committee include collection of relevant material to document the activities of the Council, summarizing activities and listing goals for the next year in accordance with the Council's priorities, and recommendations to the Governor and MHA. The draft of the report shall be completed in November, submitted to the Council in December for approval, and submitted to the Governor by January 31. The Council Chairperson shall appoint members to this committee no later than September.

H. Ad Hoc Committees and Special Studies/Workgroups

The Chairperson may appoint temporary committees or Council representatives for a specified purpose and time. Upon completion of the task, the committee shall be dissolved. Examples of ad hoc committees are as follows:

1. Ad Hoc Committees

The duties of these committees are to address a specific mental health priority area identified by the Joint Council for review, presentation, and possible advocacy recommendation.

2. Special Studies/Workgroups

The duties of this committee may include an individual(s) representing the Council on various Mental Hygiene Administration or other agency or organization sponsored task forces, workgroups, etc.

Article VII: Amendments

The By-laws may be amended by recommendations of the Executive Committee and two-thirds of the voting members of the Council who are present, provided that copies of the proposed amendments and notice for consideration have been mailed to every member at least two weeks before the date of the meetings, during which adoption of the amendment(s) would be considered.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

**TABLE 1. List of Planning Council
Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Albizo, Lynn H.	Others(not state employees or providers)	National Alliance for Mental Illness - Maryland	10630 Little Patuxent Parkway, Suite 475 Columbia,MD 21044 PH:410-884-8691 FAX:	
Allenza, Carol	Family Members of Children with SED	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy Suite 119 Columbia,MD 21044 PH:410-730-8267 FAX:	
Blair, Richard W.	State Employees	Criminal Justice	6515 Coffman Farms Road Keedysville,MD 21756 PH:301-432-2924 FAX:	
Bohrer, Terezie	Others(not state employees or providers)	Mental Health Association, Inc.	16304 Bawtry Court Bowie,MD 20715 PH:301-262-2772 FAX:301-262-3797	
Bryant, Tracee E.	Others(not state employees or providers)	Black Mental Health Alliance, Inc.	733 West 40th Street Suite 10 Baltimore,MD 21215 PH:410-338-2642 FAX:410-338-1771	
Burns, Sarah	Consumers/Survivors/Ex-patients(C/S/X)		1631 Ingleside Avenue Apt #26 Baltimore,MD 21207 PH:443-200-5701 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

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TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Cohen, Peter R.	State Employees	Other	Alcohol and Drug Abuse Administration 55 Wade Avenue Catonsville,MD 21228 PH:410-402-8677 FAX:410-402-8601	
Cromwell, Herb	Providers	Community Behavioral Health Association of Maryland	18 Egges Lane Catonsville,MD 21228 PH:410-788-1865 FAX:410-788-1768	
Cuozzo, Lisa	Others(not state employees or providers)	Mental Health Association of Maryland, Inc.	711 W. 40th Street Suite 460 Baltimore,MD 21211 PH:410-235-1178 X208 FAX:410-235-1180	
Diehl, M. Sue	Others(not state employees or providers)		6005 Lake Manor Drive Baltimore,MD 21210 PH:410-377-4446 FAX:	
Drake, Catherine	State Employees	Vocational Rehabilitation	2301 Argonne Drive Suite A304 Baltimore,MD 21218 PH:410-554-9440 FAX:410-554-9412	
Finkle, Michael S.	Consumers/Survivors/Ex-patients(C/S/X)	On Our Own of Maryland, Inc.	On Our Own of Maryland 1521 S. Edgewood Street, Suite C Baltimore,MD 21227 PH:410-646-0262 X13 FAX:410-646-0264	

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Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Froehlinger, Vira	State Employees	Education	1 Southerly Court Towson, MD,MD 21286 PH:410-767-0722 FAX:	
Gibson, A. Scott	Consumers/Survivors/Ex-patients(C/S/X)		P.O. Box 561 Frostburg,MD 21532-0561 PH:301-697-8560 FAX:	
Goga, Joshana	Providers	Medical Profession	1158 East MacPhal Road Bel Air, MD,MD 21015 PH:410-441-9999 FAX:	
Gray, Geraldine	Family Members of adults with SMI		1 Hamill Road #D Baltimore,MD 21210 PH:410-433-9263 FAX:	
Herr, Diane C	State Employees	Medicaid	201 W. Preston Street Room 200 Baltimore,MD 21201 PH:410-767-5204 FAX:	
Jerscheid, Julia	Consumers/Survivors/Ex-patients(C/S/X)		201 Federal Street #33 Easton,MD 21601 PH:410-822-4917 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

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Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Johnson, Heather R.	Consumers/Survivors/Ex-patients(C/S/X)		P.O. Box 22 Worton,MD 21678 PH:410-778-4908 FAX:	
Kauffman, Cindy	State Employees	Other	1401 Severn Street Baltimore, MD,MD 21230 PH:4102348203 FAX:	
Lang, Michael	Consumers/Survivors/Ex-patients(C/S/X)		10720 Georgia Avenue Apt. #104 Wheaton,MD 20902 PH:301-942-8285 FAX:	
Lipford, Sharon	Providers	Maryland Association of Core Service Agencies	Harford County Core Service Agency 29 West Courtland Street Bel Air,MD 21014 PH:410-803-8726 FAX:410-803-8732	
Lipman, George M.	Others(not state employees or providers)		Hargrove District Court 700 E. Patapsco Avenue Baltimore,MD 21225 PH:410-878-8963 FAX:	
Liss, Phoenix	State Employees	Other	Maryland Department of Aging 301 W. Preston Street Rm. 1007 Baltimore,MD 21201 PH:410-767-4665 FAX:	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

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HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

TABLE 1. List of Planning Council Members

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Oliver, Edwin C.	Providers		C/o Baltimore Lab 2220 St. Paul Street Baltimore,MD 21218 PH:410-261-5500 FAX:	
Pazourek, Livia	Others(not state employees or providers)		578 Belmawr Place Millersville,MD 21108 PH:410-768-6777 X234 FAX:410-760-6811	
Pender, Robert	Others(not state employees or providers)		Box 294 Terry Drive Port Tobacco,MD 20677 PH:301-934-3145 FAX:	
Petion, Cynthia	State Employees	Mental Health	Spring Grove Hospital Center 55 Wade Avenue-Dix Bldg Cationsville,MD 21228 PH:410-402-8473 FAX:410-402-8309	
RachBeisel, Jill	Others(not state employees or providers)	University of Maryland, Dept. of Psychiatry	701 West Pratt Street Room 354 Baltimore,MD 21201 PH:410-328-5161 FAX:410-328-3311	
Rafferty, Cindy	State Employees	Housing	100 Community Place Crownsville,MD 21032 PH:410-514-7537 FAX:410-987-3721	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

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HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

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Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Raines, Linda J.	Others(not state employees or providers)	Mental Health Association of Maryland, Inc.	711 West 40th Street Suite 460 Baltimore,MD 21211 PH:410-235-1178 X204 FAX:410-235-1180	
Reifsnider, Charles	Consumers/Survivors/Ex-patients(C/S/X)		10134-B Liberty Road Frederick,MD 21701 PH:301-898-3044 FAX:	
Reinsel, James	State Employees	Other	217 E. Redwood Street Suite 1300 Baltimore,MD 21202 PH:410-767-3635 FAX:	
Rhine, Sarah	Others(not state employees or providers)	Maryland Disability Law Center	1800 North Charles Street #400 Baltimore,MD 21201 PH:410-727-6352 FAX:	
Rigsby, Michelle	Family Members of Children with SED		1542 Forest Park Avenue Baltimore,MD 21207 PH:410-788-9470 FAX:	
Solomon, Anita	Providers		7517 Holiday Terrace Bethesda,MD 20817 PH:301-340-0999 FAX:301-229-0833	

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

**THE MARYLAND ADVISORY COUNCIL ON MENTAL
HYGIENE/102-321 PLANNING COUNCIL MEMBERSHIP LIST**

**TABLE 1. List of Planning Council
Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Sparer, Sheryl	Consumers/Survivors/Ex-patients(C/S/X)		1612 Hilltop Road Edgewater,MD 21037 PH:443-716-5322 FAX:	
Thompson, Garth	Others(not state employees or providers)		213 Ridgemeade Road Baltimore,MD 21210 PH:410-467-0365 FAX:410-467-0365	
Walker, Jane	Family Members of adults with SMI	Maryland Coalition of Families for Children's Mental Health	10632 Little Patuxent Pkwy. Suite 119 Columbia,MD 21044 PH:410-730-8267 FAX:	
Ward, Kathleen	State Employees	Social Services	311 W. Saratoga Street Room 259 Baltimore,MD 21201 PH:410-767-7422 FAX:410-333-6696	
Williams, Della	State Employees	Social Services	311 W. Saratoga Street Room 503 Baltimore,MD 21201-3521 PH:410-767-7630 FAX:	
Zahm, Carol	State Employees	Criminal Justice	120 West Fayette Street Baltimore,MD 21201 PH:410-230-3122 FAX:	

Council Composition by Type of Member

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	42	
Consumers/Survivors/Ex-patients(C/S/X)	8	
Family Members of Children with SED	2	
Family Members of adults with SMI	2	
Vacancies(C/S/X and Family Members)	0	
Others(not state employees or providers)	12	
TOTAL C/S/X, Family Members and Others	24	57.14%
State Employees	13	
Providers	5	
Vacancies	0	
TOTAL State Employees and Providers	18	42.86%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide

adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider

members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may

include public and private entities concerned with the need, planning, operation, funding, and use of mental health

services and related support services. 4) Totals and Percentages do not include vacancies.

G. ROLE OF THE MARYLAND ADVISORY COUNCIL ON MENTAL HYGIENE/PL 102-321 PLANNING COUNCIL IN IMPROVING THE PUBLIC MENTAL HEALTH SYSTEM

During FY 2010, the Joint Council followed closely the progression of events within the PMHS through reports from the Executive Director of MHA and through various presentations throughout the year. Presentations included: a second year progress meeting with the DHMH Deputy Secretary of Behavioral Health and Disabilities, telemental health in Maryland, activities of the Systems Evaluation Center, Maryland's Co-occurring (mental health and substance addiction) System of Care, the Outcomes Measurement System, the Employed Individuals with Disabilities Program, an update on child and adolescent services issues, and an update on activities of the Mental Health Transformation Office. Additionally, The Joint Council received reports from members who represented individual state agencies. Information from these presentations assists the Joint Council in understanding the PMHS and its programs, which aids in its advocacy work at the national, state, and local levels.

In addition to the duties of Joint Council membership, some members serve either as Council representatives or in their organizational capacities, on various workgroups and task forces of the PMHS which provides important output into the planning and policy development of the PMHS. During FY 2010, some of these workgroups impacted areas of: consumer recovery and leadership, Mental Health Transformation, implementation of evidence-based practices, coordination of care and systems of care for youth, older adults, Wellness Recovery Action Plan (WRAP), peer-operated Wellness and Recovery Centers, criminal justice, suicide prevention, children's school-based mental health, and the State Mental Health Plan development.

On October 21 and 22 The Council Chair represented the Council on the Northeast Regional Peer Review meeting on Maryland's Mental Health Block Grant in Charleston, South Carolina. Peer reviewers from other states in the region, review and evaluate each state's application. The Chairman added Maryland had received favorable reviews of the state's application and the innovations in Maryland's Public Mental Health System (PMHS). Additionally, each year the Joint Council is represented at the CMHS National Mental Health Block Grant and Data Infrastructure Grant Conference on and National Conference. In 2010, a Council member, representing consumer and family advocacy, attended the conference which included a Training session for Planning Council Representatives conducted by the National Association of Mental Health Planning Advisory Councils (NAMHPAC).

The Joint Council closely follows the developments of Maryland's federal Mental Health Transformation State Incentive Grant, which ends its five-year tenure in the fall of 2010. Due to its exemplary work, Maryland was chosen to host the SAMHSA Mental Health Transformation Summit which took place in Annapolis in July 2009 during which all states receiving the MHT-SIG were represented. Over the past year, Maryland's Mental Health Transformation Office has continued to undertake a number of innovative projects to transform the mental health system and build upon both transformational

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

efforts that pre-date Maryland's grant award and strategies that began during the first four years of the Grant (MHT-SIG). Representatives from the Joint Council serve on the Transformation Working Group (TWG) and its various sub-committees, which were formed to oversee grant activities in the areas of Mental Health First Aid, cultural competence of the mental health workforce, affordable housing, continued Wellness and Recovery Action Plan (WRAP) training, development of Centers of Excellence (providers who serve as guide agencies for service delivery through the recovery model), projects to strengthen service infrastructure to support older adults, and child well-being and systems of care initiatives. Emphasis has been placed on ensuring statewide impact and sustaining MHT-SIG efforts. A new grant has been submitted to the Substance Abuse and Mental Health Services Administration (SAMHSA) to increase opportunities for career development and wellness and recovery for adults with serious mental illness through the integration of Evidence-Based Practice Supported Employment with On-site Benefits Counseling, Self Directed Care, and WRAP.

The Joint Council received, as it does annually, an overview of the FY 2010 Maryland Legislative session's mental health activities through the Legislative Committee and other members of advocacy organizations. During MHA's budget hearings before the State Senate and the State House of Delegates, the Legislative Committee and the Executive Committee, consisting of Council officers, provided input to representatives of the Joint Council who gave testimony at these hearings on behalf of the funding needs of the PMHS.

The Joint Council remains actively involved in the development of the State Mental Health Plan and Block Grant Application. In the introduction to the most recent State Mental Health Plan, it is noted that MHA goals, objectives, and strategies reflect much of what occurred through the community's involvement and discussions surrounding the continued efforts of the mental health transformation effort (infused throughout the MHA State Mental Health Plan for adults, youth, and children) and ideas from SAMHSA's Ten Strategic Initiatives, which fit well with MHA's mission of a wellness and recovery focus, also infused throughout the efforts of the PMHS.

Planning Committee members positively noted several items including MHA's:

- Commitment to increase the availability of consumer and family-operated support as noted in this year's strategy to amend Maryland's Medicaid State Plan for community services to add Peer Support services, Supported Employment, and Crisis Services will promote the goals of recovery and resiliency
- Implementation of the SAMHSA system of care grants, utilizing Care Management Entities (CMEs), with a special focus on children and youth in foster care in Baltimore City; and in nine Eastern Shore counties
- Maryland's Psychiatric Residential Treatment Facility (PRTF) demonstration waiver to provide services in the community for children and adolescents who would otherwise be eligible for residential treatment level of care (one of nine states to be approved)

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011

- Promotion of Employed Individuals with Disabilities and other opportunities for increased employment

At the start of FY 2011, the Planning Committee met again to review and make recommendations for key sections of Maryland's FY 2011 Community Mental Health Services Block Grant (MHBG) Application, which incorporates strategies from the FY 2011 State Mental Health Plan.



State of Maryland

Advisory Council on Mental Hygiene/Planning Council

Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – John M. Colmers, Secretary, DHMH

August 13, 2010

Barbara Orlando
Grants Management Specialist,
Division of Grants Management, OPS, SAMHSA
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville MD 20857 (for First Class Mail) 20850 (Overnight Express)

RE: FY 2011 Mental Health Block Grant Application

Dear Ms. Orlando:

As a mandate of Public Law 102-321, the Maryland Advisory Council on Mental Hygiene/Planning Council submits this report of our review of the FY 2011 State Mental Health Plan and Mental Health Block Grant (MHBG) application. This council, referred to as the Joint Council, is composed of consumers, family members of persons with psychiatric disabilities, mental health professionals, representatives of other State agencies, and other interested citizens and is an important source of advice and advocacy in Maryland. The Joint Council also is in compliance with Maryland's law requiring the mental health advisory council to review plans and submit any recommended modifications to the state. In accordance with Section 1915(a) of the Public Health Service Act, this letter includes public comments on the Maryland planning process, forms of advocacy employed by the mental health planning council, and recommendations on the FY 2011 State Mental Health Plan and Mental Health Block Grant Application.

Maryland is proud of its strong and well-developed coordination of consumer, family, advocacy, and provider participation in our Public Mental Health System (PMHS). Maryland's PMHS' strengths were recognized with selection of Maryland as one of seven states to receive a Mental Health Transformation State Incentive Grant (MHT – SIG) of \$13.5 million over five years from SAMHSA. The Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council values the unique level of access and participation in both the planning and operation of the PMHS and is closely following the work of the Maryland Health Care Reform Coordinating Council.

c/o Mental Hygiene Administration

Spring Grove Hospital Center – 55 Wade Avenue – Dix Building – Catonsville MD 21228 – (410) 402-8473

TDD for Disabled – Maryland Relay Service (800) 735-2258

Healthy People in Healthy Communities

The Joint Council is pleased to report that despite the challenges of the State and national economic crisis, which has dramatically reduced State tax revenue, State leadership has maintained access to services in the Public Mental Health System. The number of consumers who received services has actually increased approximately 7-8% in the past year. In recent years access to care for the uninsured has been a focus of the Joint Council's advocacy efforts. This February we testified at both MHA budget hearings that: "cuts to community services would drive up utilization of higher cost emergency room and inpatient services". This fiscal year, the Joint Council will continue to emphasize the "importance of maintaining the safety net focused on more efficient community services" and to continue to advocate for maintaining PMHS access for uninsured consumers with mental illness who are not covered by Medicaid.

Our Joint Council meets monthly with our Mental Hygiene Administration (MHA) Director and key agency staff. During FY 2010, the Joint Council followed closely the progression of events within the PMHS through reports from the Executive Director of MHA and through various presentations of activities surrounding family and children's initiatives including: Maryland's Outcome Measurement System, Employed Individuals with Disabilities, Child and Adolescent Mental Health Institute, activities of system's change, Maryland's co-occurring system of care, implementation of evidence-based practices, mental health and the criminal justice system initiatives, and telemental health services. Joint Council members, either as Council representatives or in their organizational capacities, also serve on numerous task forces and workgroups. In FY 2010, this included participation of several consumer and family leadership representatives on the Transformation Working Group (TWG). Additionally, the Joint Council provided testimony on MHA's budget at hearings before key Committees of the State Legislature. (Please refer to Section G – Role of the Maryland Advisory Council.)

The Joint Council is actively involved in the development of the State Mental Health Plan and the Federal Mental Health Block Grant Application. The Planning Committee is now monitoring public mental health system data and participating in our planning process year round. In 2010, a series of Planning Committee meetings were held to develop and review these key documents:

- The Planning Committee, which meets as needed after the full Council meeting, discussed priorities and prepared for the MHA public meeting on April 29, 2010 to develop the State Mental Health Plan. This year the meeting included broader participation of representatives. More than 75 representatives of mental health advocacy organizations, wellness and recovery centers, Core Service Agencies (CSAs), local mental health advisory committees, and members of the MHA Management Committee attended. The meeting was reformatted to include five breakout groups with each focused on two SAMHSA *Ten Strategic Initiatives* to develop strategy concepts for the 2011 Plan.
- The Planning Committee of the Joint Council met on July 15th to review a draft of the Goals, Objectives, and Strategies for the FY 2011 Plan and modified, expanded, and strengthened the strategies as appropriate.

- On July 20th the Planning Committee held an additional meeting to review key sections of the FY 2011 Federal Block Grant Application, including: Section I – which highlights Maryland’s service system, progress and new developments; Section II-identification and analysis of service system’s strengths and needs; Section III – presentation of targets and action plans for the required National Outcome Measures (NOMS); and the FY 2011 Block Grant Spending Plan. Because of PMHS data issues related to the FY 2011 transition to the new ASO, Committee review of indicators was delayed until a later meeting. Planning Committee Members observed reader friendly improvements in key narrative sections of this year’s MHBG application.
- At the July 20th Joint Council meeting, members approved the FY 2011 State Plan, received the report of the Planning Committee regarding their plans and reviewed the MHBG materials from on the FY 2011 Mental Health Block Grant. The Joint Council, based on the Planning Committee’s report, approved both the State and Federal Block Grant plans. The Executive Committee was charged with completion of the final letter of review to be included in the Federal Mental Health Block Grant for submission to CMHS.

The full Maryland Advisory Council on Mental Hygiene/ PL 102 – 321 Planning Council recommends the adoption of the Plan along with the following comments which were developed following the review of the Block Grant on July 20, 2010:

- The Joint Council commends MHA’s ongoing efforts to improve the State Plan Development process. This year’s process included a full-day working meeting with an expanded group of mental health advocates and included broad representation from wellness and recovery centers across the state. The Planning Committee observed that MHA successfully revised the State Plan Goals to incorporate *SAMHSA’s Ten Strategic Initiatives*.
- In this fourth and final year of the MHT-SIG, collaboration with the Mental Health Transformation Office (MHTO) and On Our Own of Maryland provided for Wellness and Recovery Action Plan (WRAP) training in consumer-operated programs as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, and utilize best practices within the consumer movement. Also noteworthy are other MHTO supported consumer initiatives including Consumer Quality Teams and adult and child leadership institutes.
- We commend MHA’s continued commitment to increase the availability of consumer and family-operated support services. This year’s strategy to amend Maryland’s Medicaid State Plan for community services to add Peer Support services, Supported Employment, and Crisis Services will promote the goals of recovery and resiliency.
- Through our Interagency Forensic Services Committee (IFSC), we will continue to monitor activities regarding the delivery of mental health services to individuals who are incarcerated or at risk of incarceration in jails and detentions centers, including diversion from the criminal justice system, and working with Maryland’s CSAs to assist reintegration into the community following incarceration.

- We support the efforts of MHA to improve services for youth and young adults and, when appropriate, their families especially those who are in transition from the child and adolescent system to the adult life. Of special note is the Healthy Transition Initiative (HTI), a SAMHSA-funded service demonstration for youth and young adult populations in Washington and Frederick Counties.
- Also noteworthy is the continued support for the Maryland Child and Adolescent Mental Health Institute to further develop and disseminate evidence based practices (EBPs) for Children & Adolescents including, treatment foster care, high fidelity wrap-around, trauma-informed care, functional family therapy and multi-systemic therapy. Efforts include the research of best practices in psychiatry to address the reduction of negative side effects of medication and prevention of obesity and morbidity for children in the child welfare system.
- Implementation of two SAMHSA System of Care grants: Maryland CARES, with a special focus on children and youth in foster care in Baltimore City; and RURAL CARES in nine (9) eastern shore counties using Care Management Entities (CMEs) and High Fidelity Wraparound processes.
- We are especially proud of MHA's collaborative work with the Division of Rehabilitation Services (DORS) to increase the number of consumers employed through multiple strategies including evidence-based practices in supported employment. Several innovative strategies in the State Plan support this State priority as does Maryland's promotion of the Ticket to Work and Employed Individuals with Disabilities Program (EID).
- The availability of affordable housing remains a particularly critical need for consumer independence and recovery. The Council continues to encourage and support interagency efforts to promote a range of housing and residential options in Maryland.
- The Joint Council continues to advocate for the psychiatric and somatic needs of older adults. In response to our advocacy MHA, through the Mental Health Transformation Office (MHTO), provided staff resources to undertake several strategies to enhance the coordination of care between somatic and behavioral health care providers. We support MHA's focus on smoking cessation as a key response to disparities in mortality rates for people with mental illness.
- This year the Maryland Suicide Commission was established pursuant to an Executive Order, by the Maryland Department of Health and Mental Hygiene (DHMH). We support Maryland's continued implementation of pilot projects for identified high risk counties, prevention activities for youth, adults, and older adults.

In summary, the Joint Council commends the work of the MHA staff in collaborating with key stakeholders in planning and implementing systems' change and will closely monitor the activities surrounding Maryland's Commission on Health Care Reform. We are pleased with the emphasis on consumer participation and direction throughout the PMHS. Our involvement in the ongoing development of the PMHS and the opportunities identified through this year's State Mental Health Plan to continue to improve the system, including ways to increase our role as a proactive force in the planning and priority setting processes, contributes to the ongoing success of the public mental health system. We will continue to advocate strongly for maintaining access to services, especially for uninsured consumers and look forward to Maryland's implementation of Health Care Reform as a way to improve access to care. The Joint Council fully supports the current Mental Health Block Grant Application.

Sincerely,

M. Sue Diehl
Chairperson

cc: The Honorable Martin O'Malley, Governor
John M. Colmers, Secretary, DHMH
Brian Hepburn, M.D., Executive Director, MHA

PART C. STATE PLAN

SECTION I. DESCRIPTION OF STATE SERVICE SYSTEM

In this section, States are requested to identify any issues or initiatives within the State that are important in understanding the State plan in the context of the broader system.

Maryland ranks 42nd among the States in size with 9,844 square land miles and total area (including inland water and the Chesapeake Bay) of 12,193 square miles. Maryland ranks 19th in population among the States and ranks 6th in population density with 541.9 persons per square land mile. Maryland's population increase was approximately .9% annually according to Maryland Department of Planning. However, in recent years Maryland's population estimates are slowing. In 2008 Maryland's population estimate was 5,633,597, a slight increase of (15,253) only 0.3% from the 2007 tally of 5,618,344 according to calculations from Maryland Vital Statistics Annual Report 2008, which is based upon the ten years U.S. Census.

Maryland ranked 4th among the States with per capita income in 2008 growing to \$48,091. This average fails to capture the great economic diversity and the disparity that exists between the counties such as Montgomery County with the highest per capita income of \$67,525 and Somerset County with the lowest per capita income of \$24,053. In 2008, average household median income for the State was \$70,545 the second highest in the nation Maryland's workforce is one of the best educated, across the states, with over one third of its population 25 years or older having at least a college degree. Maryland ranks second among the states with 15.4% of the population aged 25 or older having a graduate or professional degree. (Source – Maryland Department of Business and Economic Development www.choosemaryland.org/factsandfigures/demographics) In recent years Maryland's funding under this Community Mental Health Block grant has been reduced due to formula shifts like the State's high economic standing.

Local government entities exist in Maryland's 23 counties, Baltimore City, and 154 municipal corporations (including Baltimore City). The Constitution of Maryland requires that the State budget be balanced and total estimated revenues must equal or exceed total appropriations. The Governor presents the budget, and the legislature can only approve or reduce.

About 90% of the population lives in the densely populated corridor between Baltimore City and Washington, D.C. (Maryland Department of Business and Economic Development, 2004). The 2000 Census Data show Maryland's population based on age and sex closely mirrors the United States population. However, Maryland consists of 30.0% African Americans, as opposed to the United States' 12.3%. There is a larger Asian population (5.3%) and more individuals of Hispanic or Latino origin (6.3%), compared respectively to the United States' figures of 3.6% and 2.5%. American Indian or Alaska Native persons make up less than 1.0% of Maryland's population, while they make up .9% of the United States' population (US Census for national 2000 and Maryland Vital Statistics Annual Report 2008).

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In June 2010 a total of 881,128 individuals were in Medical Assistance or one of the coverage groups included in the Maryland Department of Health and Mental Hygiene's HealthChoice Information System. This is an increase of 7.5% over the previous June, 2009 enrollment of 819,441. In June 2010, 96,644 children up to age 19 were enrolled in the Maryland Children's Health Program (MCHP). In June 2010, MCHP enrollment decreased by 5,644 from the previous year to 102,288. (Medicaid eligibility data is from the Website (<http://www.chpdm-ehealth.org/eligibility/new/index.cfm>)).

Overview of the State's Mental Health System

- **An overview of the State's mental health system: a brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.**

The Mental Hygiene Administration (MHA) is the agency within the Department of Health and Mental Hygiene responsible for the oversight of public mental health services in Maryland. Maryland operates the majority of its public mental health system under a Medicaid 1115 waiver. The waiver permits the Secretary of DHMH to require that all Medical Assistance (MA) recipients, except certain exempted populations, be enrolled in and receive their somatic care through managed care organizations (MCOs). Waiver-eligible Medical Assistance recipients are enrolled in MCOs under Maryland's HealthChoice program. Under the terms of the waiver, MCOs receive a capitated rate for providing somatic care, substance abuse treatment, and primary mental health care to enrollees. Primary mental health services, as defined by the enabling legislation, means the clinical evaluation and assessment of mental health services needed by an individual and the provision of services or referrals for mental health services as deemed medically appropriate by a primary care provider. Both the MCOs and MHA are required to assure that somatic care and substance abuse treatments are coordinated with mental health care.

Under Maryland's 1115 Medicaid waiver, a redesigned public mental health system (PMHS) was conceptualized. Specialty mental health services - those mental health services that are beyond primary mental health services - are delivered through a "carve-out" arrangement that manages public mental health funds under a single payor system. The system serves Medicaid recipients and a subset of uninsured individuals who meet medical necessity criteria and financial and/or other specific criteria. The cost of mental health services is subsidized, in whole or in part with State general funds. Medically necessary mental health services are delivered to eligible individuals of all ages through the PMHS.

Prior to the waiver, MHA administered all State funds allocated to it by the legislature for mental health services as well as some federal grant funds, but only a portion of the State and federal Medicaid dollars, specifically money that paid for services under the Medicaid clinic, rehabilitation and targeted case management options. Through implementation of the public mental health system, July 1997, MHA began to

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administer all State and federal, including Medicaid, funds related to mental health services. Coverage includes both Medicaid recipients and the uninsured population. In FY 2010, 117,498 people of all ages received mental health services.

The PMHS is managed in collaboration with the Core Service Agencies (CSAs) and the Administrative Services Organization (ASO). The CSAs are entities at the local level that have the authority and responsibility, in collaboration with MHA, to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. On September 1, 2009, MHA began a five year contract with ValueOptions, Inc., the new ASO, for Maryland's PMHS, referred to as ValueOptions® Maryland. The major responsibilities of Value Options include: access to services, utilization management, data collection and management information services, claims processing and payment, evaluation services, and stakeholder feedback. The goal of the system is to provide the benefits of the coordination of managed care, while preserving access to a comprehensive array of services, flexibility, and choice.

From the time of admission, facilities work collaboratively with CSAs, community providers, consumers, and families toward patient discharge. The focus is on returning the individual to the lowest level of care necessary to meet the individual's medical needs. The State psychiatric hospitals are participants, along with the acute general hospitals and the private psychiatric hospitals, in the provision of psychiatric inpatient care in Maryland. MHA currently operates six inpatient psychiatric facilities that provide intermediate and long-term care for adults. Springfield Hospital Center offers inpatient care for individuals who are deaf or hard of hearing. In addition, MHA operates one psychiatric forensic facility and two residential treatment facilities for youth known as Regional Institutes for Children and Adolescents (RICAs). However, in FY 2010, as a result of budget reductions, changes to the facilities occurred. In October 2009, MHA closed Walter P. Carter Center, an acute care State facility in Baltimore City. The functions for those inpatient services moved to Spring Grove Hospital Center. In February 2010, Upper Shore Community Mental Health Center was closed. Services shifted to the community with an infusion of funding allowing the Eastern Shore community providers to further develop and implement the types of services required and to expand options beyond traditional hospitalization. The Mental Hygiene Administration, in collaboration with the various stakeholders, continue to have dialogue on developing and implementing a continuum of inpatient psychiatric care across the private and State sectors and defining the roles of each sector in the provision of acute and long-term care for individuals with Medical Assistance and those who are uninsured.

MHA recognizes that individuals with serious mental illnesses (SMI) and serious emotional disturbances (SED) often require services that are provided by other State departments and administrations, such as the State Department of Education, the Division of Rehabilitation Services, the State Department on Aging, the Governor's Office for Children, the State Department of Human Resources, the State Department of Juvenile Services, the State Department of Housing and Community Development, and other administrations within the Department of Health and Mental Hygiene. To ensure adequate access to those services, MHA maintains interagency agreements, and

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designated liaisons with those agencies, as well as many others. Through Maryland's Mental Health Transformation State Incentive Grant, two Children's Mental Health Initiative grants (Systems of Care grants), and a Community Alternatives to Psychiatric Residential Treatment Facilities Medicaid demonstration waiver, these interagency collaborations and partnerships continue to be solidified while new ones will be formed to further build the infrastructure to coordinate care and improve service systems.

- **A brief description of regional/sub-State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.**

Core Service Agencies (CSAs) are the entities at the local level that have the authority and responsibility to develop and manage a coordinated network of Maryland's public mental health services in a defined service area. There are nineteen (19) CSAs covering all 24 jurisdictions. CSAs are agents of county or city government and may be county departments, quasi-government bodies, or private non-profit corporations. They vary in size, needs, budgets, and budget sources. CSAs are the administrative, program, and fiscal authority which are responsible for assessing local service needs and planning the implementation of a comprehensive mental health delivery system that meets the needs of eligible individuals of all ages.

MHA and CSAs share responsibilities in the PMHS. Together, they are responsible for determining the criteria for utilization management, establishing performance standards, and evaluating appropriateness and effectiveness of service. Additionally, CSAs are important points of contact for both consumers and providers in the PMHS and develop partnerships with other local, state and federal agencies. CSAs provide numerous public education events and trainings. They are responsible for processing complaints, grievances, and appeals, as well as for monitoring the contract with the ASO and reporting findings to MHA. Additionally, local mental health advisory committees and CSA Boards have the opportunity and responsibility to advise CSAs regarding the PMHS and to participate in the development of local mental health plans and budgets.

The Maryland Association of Core Service Agencies, (MACSA) Inc., was established to promote and support the effectiveness of each CSA in Maryland to plan, monitor and manage its local, publicly-funded mental health service system. Each fiscal year MHA requires that CSAs develop and report on their progress in identifying and meeting local needs and State priorities. Additionally, CSA representatives participate on the Maryland Advisory Council on Mental Hygiene/Planning Council and various MHA committees such as the Finance Committee and the Clinical Committee which promote direct involvement with PMHS issues. Also, the CSAs work closely with the MHA Management Information System (MIS) staff on the Data Committee to generate and disseminate data that is useful to the CSAs as they support initiatives and services that are the most beneficial for the public they serve.

MARYLAND MENTAL HEALTH BLOCK GRANT APPLICATION FY 2011**CORE SERVICE AGENCIES IN MARYLAND**

JURISDICTION	TITLE OF CSA	ORGANIZATIONAL LOCUS	DIRECTOR LOCATION
Allegany County	Allegany County Mental Health Systems	Part of County Health Department	Lesa Diehl Cumberland MD
Anne Arundel County	Anne Arundel Co. Mental Health Agency, Inc.	Private - Non-Profit	Frank Sullivan Annapolis MD
Baltimore City	Baltimore Mental Health Systems, Inc.	Private- Non-Profit	Jane Plapinger Baltimore MD
Baltimore County	Baltimore Co. Dept of Health, Bureau of Mental Health	Part of County Health Department	Robert Blankfeld Towson MD
Calvert County	Calvert County Health Department Core Service Agency	Part of County Health Department	Douglas Weems Prince Frederick MD
Carroll County	Carroll County Core Service Agency	Part of County Health Department	Sarah Hawkins Westminster MD
Cecil County	Cecil County Mental Health Department Core Service Agency	Part of County Health Department	Doug Sommers Elkton MD
Charles County	Charles County Human Services Partnership	Part of County Health Department	Karyn Black LaPlata MD
Frederick County	Mental Health Management Agency of Frederick County, Inc.	Private - Non Profit	Robert Pitcher Frederick MD
Garrett County	Mountain Top Mental Health Associates, Inc.	Part of County Health Department	Fred Polce Oakland MD
Harford County	Core Service Agency of Harford County	Private - Non-Profit	Sharon Lipford Bel Air MD

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JURISDICTION	TITLE OF CSA	ORGANIZATIONAL LOCUS	DIRECTOR LOCATION
Howard County	Howard Co. Mental Health Authority	Quasi-Governmental	Donna Wells Columbia MD
Mid-Shore: Kent, Caroline, Queen Anne's, Talbot, Dorchester Counties	Mid-Shore Mental Health Systems, Inc.	Private - Non-Profit	Holly Ireland Easton MD
Montgomery County	Montgomery County, Department of Health and Human Services, Mental Health Core Service Agency	Part of County Government	Raymond Crowel Rockville MD
Prince George's County	Prince George's Co. Dept. of Family Services, Mental Health Authority Division	Part of County Department of Family Services	L. Christina Waddler Hyattsville MD
St. Mary's County	Mental Health Authority of St. Mary's Co., Inc.	Part of County Health Department	Cynthia Brown Leonardtown MD
Washington County	Washington County Mental Health Authority, Inc.	Private - Non-Profit	Rick Rock Hagerstown MD
Wicomico/Somerset Counties	Wicomico-Somerset County Regional Core Service Agency	Part of County Health Department	Heather Brown Salisbury MD
Worcester County	Worcester County Core Service Agency	Part of County Health Department	Jennifer LaMade Snow Hill MD

Role of the State Mental Health Agency

- **A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.**

Mental Hygiene Administration (MHA) recognizes the importance of promoting mental health within the broader system. MHA staff have active liaisons with other State agencies, participate in other agency workgroups, and advocate for the availability of services offered in the broader system to persons with psychiatric disabilities. In 2009, MHA Executive Director, Brian Hepburn, M.D. received awards and recognition from the Maryland Rehabilitation Association for his contributions to the rehabilitation of persons with disabilities and was also presented a public service award by NAMI Maryland for his support for NAMI programs and the organization's participation in state mental health issues.

DHMH Secretary, John M. Colmers, has been the visionary lead for the Mental Health First Aid© (MHFA) program. In collaboration with the Missouri Department of Mental Health and the National Council for Behavioral Healthcare, the Mental Health Association of Maryland, and On Our Own of Maryland (OOOMD), MHA has adopted the Australian-based program to educate the general public to recognize signs of an emerging mental illness or a mental health crisis. A corps of more than 60 certified instructors throughout the state has been trained. Seventy-five trainings have been held, training more than 1,521 Marylanders. The program is being presented across Maryland in a variety of settings, including schools and universities.

Under the leadership of the Deputy Secretary, Renata Henry for Behavioral Health and Disabilities in the Department of Health and Mental Hygiene (DHMH), who oversees the department's Mental Hygiene, Alcohol and Drug Abuse (ADAA) and Developmental Disabilities (DDA) administrations, as well as the Office of Forensic Services, MHA continues efforts that support the mission to foster an integrated process for planning and collaboration to ensure a quality system of care is available to individuals with behavioral health conditions.

In June 2009, the Deputy Secretary led a delegation to a SAMHSA-sponsored National Policy Summit on Elimination of Disparities in Mental Health Care (Maryland was one of only six states selected nationally) and developed a statewide goal for an Action Plan that will initiate activities to eliminate cultural and ethnic disparities in behavioral health and disabilities throughout Maryland. The Plan includes three broad objectives: (1) Data Approaches to improve the availability of reliable data to identify systemic differences in healthcare practices and service utilization patterns; (2) Tactical approaches to increase awareness of health disparities; and (3) Organizational approaches to enhance cooperation and integration of multiple disparities initiatives within the DHMH. Also, Maryland is in the process of implementing state-of-the-art cultural competence leadership training and technical assistance throughout its provider community. This initiative is focused on building understanding and practice of cultural and linguistic competency within the PMHS and promoting policies, practices, standards and research that eliminate health care disparities.

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MHA continues to forge strong relationships with agencies responsible for housing and employment opportunities in order to create greater access to their programs. MHA has taken the lead in reaching out to the Department of Public Safety and Correctional Services to initiate, sustain, and identify potential collaborations. MHA's work with Medical Assistance, which is the major financier of the mental health system, helps that organization remain attuned to mental health needs. MHA works with other leaders from community provider associations to address workforce issues through revisions to the PMHS rate structure and collaborates with professional associations and state regulators to maintain the quality of the workforce. The Leadership of MHA meets monthly with the Maryland Advisory Council on Mental Hygiene/ PL 102-321 Planning Council to share information, communicate concerning current developments and participate in planning, monitoring and evaluations for the PMHS. (Please refer to Section G. Role of the Maryland Advisory Council on Mental Hygiene/PL 102-321 Planning Council.)

The state of Maryland continues to refine strategies to achieve organizational culture change that will transform the delivery of mental health services and fully support recovery and resilience for consumers.

- **Legislative initiatives and changes**

The 2010 legislative session included the passage of several mental health related bills:

- House Bill 11/Senate Bill 204 – Student Stigma Act – this bill, initiated by the Maryland Coalition of Families for Children's Mental Health, eliminates stigmatizing language by changing the term "emotional disturbance" to "emotional disability". Changes will be effective October 1, 2010 in special education and elsewhere.
- House Bill 269/Senate Bill 540 – Child with a Disability – Individualized Education Program (IEP) - this bill requires schools to provide assessment and other information to parents 5 business days before an IEP meeting and a completed IEP no later than 5 business days after the IEP meeting.
- House Bill 973 – Public Schools – Maryland Youth Crisis Hotline-Distribution of Information - this bill requires schools to provide students in grades 6 – 12 the Youth crisis phone number and related information printed in the school handbook and on a student's school ID card.
- Senate Bill 761/ House Bill 1335 – Mental Health – Local Correctional Facilities/Incarcerated Individuals with Mental Illness – the passage of this bill foster efforts to improve community reentry which requires local detention centers (jails) to provide a 30-day supply of psychiatric medications upon release to inmates with mental illness who were sentenced to a term of at least 60 days.
- House Bill 849 – DHMH – Home and Community Based Waiver – Denial of Access Prohibited – this bill prohibits denial of access to a Medicaid waiver program for lack of funding if an individual is eligible for 30 days of Medicaid-reimbursed nursing home services.

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- House Bill 816/Senate Bill 28 – Election Law – Voter Qualifications – Individuals Under Guardianship for Mental Disability – this bill, effective June 1, 2010, qualifies individuals under such guardianship to vote.
- Senate Bill 57 – Health Insurance – Mental Health Benefits – Group Health Plans – this bill brings Maryland’s behavioral health parity law into compliance with the federal parity law.
- Senate Bill 633/House Bill 1034 – Community Services Reimbursement Rate Commission – Rate Adjustments – Beginning in FY 2012, fees paid to community mental health and developmental disability providers by DHMH will be tied to the inflation built into state agency budgets. The inflationary adjustment cannot exceed 4%. This bill also requires DHMH to conduct a study with stakeholders to recommend a plan to develop a rate-setting methodology and study the future role of the Community Services Reimbursement Rate Commission and other entities involved in the rate-setting process. DHMH must submit a preliminary report by December 1, 2012, and a final report with its findings and recommendations by January 1, 2013.

MHA is further required to submit to the Joint Chairmen: 1) a report on Core Service Agency (CSA) review of the current grant funded services and administrative costs, and identify service needs not currently funded, with recommendations prioritizing unmet service needs of out-year funding – due December 1, 2010; 2) MHA is required to provide an update, by October 1, 2010, on the community service expansion on the Eastern Shore related to the closure of the Upper Shore Community Mental Health Center; and 3) a report on current and future Residential Treatment Centers (RTCs) capacity.

New Developments and Issues

- **A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.**

Maryland’s mental health system has seen many challenges as well as achievements over the past years. The current economic crisis occurring across the nation has had a significant impact on the State of Maryland. Declining revenues and increasing demands for services challenged the state budget and the PMHS. Service utilization increased while the PMHS budget was reduced. In FY 2010, MHA faced three rounds of budget cuts. Within MHA, a strategic decision was reached to take its share of the budget reduction from the state hospital budgets which included facility downsizing and closures. Other cost containment measures included fee for service reductions, and reduction in CSA administrative grants. Community-based services will be further challenged to meet the needs in the community and reduce hospital utilization. MHA, in collaboration with CSAs, will work to strengthen and support community-based services including diversion initiatives.

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Despite fiscal challenges, Maryland continues to refine strategies to achieve a collaborative process that will transform mental health service delivery and fully support recovery and resilience. Through the receipt of a Healthy Transitions Initiative Grant and Systems of Care Grants, awarded over the past two fiscal years, significant efforts have been implemented to improve mental health outcomes for children, youth and families served by or at risk of entering the foster care system. With a continued focus on policy, program, and quality improvement, several initiatives have been implemented that build upon the success of evidence-based practices, promising practices, and programs directed toward a sustainable recovery for individuals. Maryland's efforts in implementation of evidence-based practices, starting with the earliest involvement in the National Evidence-Based Practice Project, came into full-scale with statewide implementation of evidence-based practice models of supported employment, assertive community treatment, and family psychoeducation. Maryland's evidence-based practice of supported employment is recognized for the best outcomes in the country. Additionally, work is underway to initiate a pilot project through which an evidence-based model for co-occurring treatment is implemented at selected sites. Under the leadership of the Department's Deputy Secretary of Behavioral Health and Disabilities, there is continued collaboration with the Mental Hygiene Administration, Developmental Disabilities Administration (DDA) and the Alcohol and Drug Abuse Administration (ADAA) to develop competencies and a curriculum, as well as a method for cross-training on co-occurring disorders across the three administrations.

The PMHS also continued to see increases in the number of individuals with court-related charges or involvement in the criminal justice system. Collaborative efforts with the judicial system were implemented to divert individuals from incarceration when appropriate, while maintaining compliance with court orders and judicial recommendations. Diversion efforts include crisis intervention teams (CITs), mobile crisis teams (MCTs) and assertive community treatment (ACT). CSAs have the discretion to choose which services to develop with support from MHA.

Maryland's community forensics and community criminal justice initiatives continue to flourish. Over 1,000 individuals were served in the detention centers and 98 individuals were served in the community through the Trauma, Addictions, Mental Health, and Recovery (TAMAR) Program, which provides trauma-based treatment for incarcerated men and women with mental illnesses who have histories of trauma. Restructuring of a program for pregnant women with histories of substance use, mental illness, and trauma, who would otherwise be incarcerated has resulted in improved working relationships among a variety of State agencies and the Baltimore City judiciary. The initiative, known as the Chrysalis House Healthy Start Program, consists of a 16-bed diagnostic and residential facility in Baltimore City for pregnant and post-partum women and their babies. Pregnant women are referred by the courts, the Office of the State's Attorney, the Office of the Public Defender, defense attorneys, and correction facilities or DHMH.

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Additionally, through the Mental Health Transformation Grant, Maryland has launched the first statewide Youth M.O.V.E. (Motivating Others through Voices of Experience) so that youth with mental illness develop significant leadership roles in the system. Half of the state is now covered by this program. Local organizations are being developed to support young participants in Youth MOVE.

Maryland was awarded, one of the 10 Psychiatric Residential Treatment Facility (PRTF) Demonstration Projects from Center for Medicare and Medicaid Services (CMS). This allowed the state to apply for a 1915(c) waiver to provide community-based services to children who meet the medical necessity criteria for admission to a PRTF but who can be served in the community using high fidelity wraparound services (Maryland Wraparound). The recently approved 1915 (c) Waiver will cover care coordination and services would be paid for by Medicaid (50/50 state match). The target population for the PRTF waiver are children under 18 years of age with serious emotional disturbance who meet the Maryland PRTF level of care. Children do not have to be eligible for Medicaid or MCHP. The waiver will provide services for up to 210 children and youth and their families.

MHA accomplished many of its objectives in the past year. Many more achievements are noted in Sections II and III of this document and their descriptions will not be repeated here. Maryland's FY 2011 State Mental Health Plan includes SAMHSA'S Strategic Initiatives. In reviewing the FY 2011 State Mental Health Plan and this Maryland Mental Health Block Grant Application, the Plan Review Committee of the Joint Council (see Part One, Section IV) noted that Maryland's objectives and strategies are congruent with efforts that promote consumer and family involvement, recovery and resiliency, prevention and early intervention, interagency collaboration and system improvement.

Maryland has worked with service providers to develop a recovery oriented system. MHA implemented regulations requiring clinics and psychiatric rehabilitation programs to operate in accordance with recovery principles. These regulations provided motivation for providers to change their practices. MHA made system-wide training available for all providers and now has established Centers of Excellence among leading providers. This project will provide state-of-the-art training and technical assistance, overseen by the Recovery Training Institute of On Our Own of Maryland, to ensure that recovery is optimally supported within these provider organizations. Once trained, the Centers of Excellence will serve as mentors to other organizations throughout the state. It is believed that Maryland's efforts to ensure recovery are among the most comprehensive in the country.

In conjunction with the changes at the provider level, changes were also being made at the consumer level. All of Maryland's consumer drop-in centers have been converted to wellness and recovery centers. This change emphasizes health and mental wellness that will allow consumers to attain recovery through a proactive response to triggers and health issues and the adaptation of a healthy lifestyle. Transformation is also providing individually targeted technical assistance to each center to ensure that they are

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optimally positioned to provide support for all consumers who seek to achieve wellness and recovery. Recommendations will be implemented to support efforts to reduce health disparities and to achieve better mental health outcomes.

In the previous year, the Mental Health Transformation Office and MHA's Office of Consumer Affairs, with the support of OOOMD began to offer training in the Wellness Recovery Action Plan (WRAP), in all of its consumer 'Wellness and Recovery' Centers across the state. There are 90 trained WRAP facilitators and over 2,700 people have received WRAP introduction /orientation training. To date it is estimated that at least 300 Marylanders, including Wellness and Recovery Centers' staff and volunteers, have participated in the introductory WRAP training and have completed personal Wellness and Recovery Action Plans.

The new emphasis on wellness and recovery allowed for the development of many innovative programs. The Self-Directed Care (SDC) Program was created to place consumers at the center of decision-making that affects them by promoting self-determination, recovery, and personal responsibility. Consumers can set their own recovery and wellness goals utilizing services and supports outside of the traditional mental health system. When the evaluation of SDC is concluded, information may be used to support grant applications and program expansion. Johns Hopkins Bayview Medical Center used the SDC model when it was developing a recent application for primary and behavioral health care integration. Even though the application was not funded, Hopkins will now increase its efforts to include non-traditional mental health supports such as gym memberships and art classes in treatment plans.

Additional programs include Consumer Quality Teams, which were developed to empower individuals who receive services to be partners with providers, policy makers and family members to improve services in the public mental health system and ensure that those services are person-centered.

While the consumer-run Anti-Stigma Project predates Transformation, this is the first opportunity to scientifically evaluate the program's effectiveness in changing people's beliefs about mental illness and recovery. Results from the evaluation will allow OOOMD to enhance this dynamic program and continue training across the country. Lastly, the creation of a Development Director position at OOOMD will provide consumer organizations with the ability to raise revenue outside of traditional funding sources, thereby expanding its funding base.

While inter-agency collaboration is not new, the level of cooperation among agencies is at an all-time high. This collaboration is one of reasons that Maryland has been able to bring in over \$30 million in grant funds targeting mental health issues over the past two years. Since receiving system of care grants in Montgomery County and Baltimore City several years ago, Maryland has been setting up a statewide system of care for children. The receipt of two new systems of care grants and a transition-aged youth grant will build on the momentum of Transformation.

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The collaborative support of multiple local and state agencies and stakeholders has made Maryland nationally known for innovations in child and adolescent services. The Governor's Office for Children has provided a mechanism for coordinating and developing effective services across child serving agencies. The Department of Human Resources received partial funding to build on MHA crisis systems to provide crisis stabilization services to prevent disruptions in foster care placements. It is expected that the new system will go statewide when the economy improves. Maryland also embedded two evidenced-based practices for children, Functional Family Therapy and Multisystemic Therapy, within its Medicaid regulations.

Maryland's Children's Cabinet has become the collective champion for the continued transformation of our system of care as evidenced by the statewide regional contracts for care management entities (and wraparound service delivery), new Medicaid and Mental Health regulations, and investment into the Innovations Institute and Children's Mental Health Institutes at the University of Maryland. These Institutes will continue to be the hub of policy and fiscal analyses, research, evaluation, training, and technical assistance.

Maryland's Commitment to Veterans, implemented in FY 2008 is a three-year collaborative partnership among the Department of Health and Mental Hygiene (DHMH), the U.S. Department of Veterans Affairs, the Maryland Department of Veterans Affairs, and the Maryland Defense Force. The project, funded by the State of Maryland, is designed to help combat veterans and their families obtain the behavioral health services they need upon the veteran's return from conflict. The primary objective is helping Veterans of the Iraq and Afghanistan conflicts link to eligible services within the U.S. Department of Veteran Affairs. Maryland was the first state in the country to add a comprehensive veterans' portal to the state's Network of Care site as an additional resource to obtaining access to services.

SECTION II

**IDENTIFICATION AND ANALYSIS OF THE
SERVICE SYSTEM'S STRENGTHS, NEEDS, AND PRIORITIES**

Adult

IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES

Maryland's Mental Health Transformation

The state of Maryland continues to refine strategies to achieve organizational culture change that will transform the delivery of mental health services and fully support recovery and resilience for consumers. As Maryland completes the fifth and final year of the Transformation grant, many projects have been sustained and many more have reached a level of momentum that the state is confident will continue beyond the life of the grant. Emphasis is currently being placed on ensuring the transition of services to individuals and organizations outside the Transformation Office, thereby sustaining MHT-SIG efforts.

As part of the Government Performance Reports Act (GPRA), seven GPRA infrastructure indicators were developed to measure system changes for all the transformation states. Maryland has already:

- Made at least eight significant policy changes, including three regarding the financing of mental health-related services
- Trained approximately 1,385 individuals in mental health best practices
- Made four significant organizational changes to support transformation
- Expanded data accountable systems across ten organizations
- Implemented state-of-the-art mental health practices relevant to the New Freedom Commission goals in over 40 programs.

Sustainability for any system transformation is defined not only by its ability to develop financing strategies, but also by its ability to grow grass-roots support, cultivate cultural competence, and grow leadership within consumer, youth, and family partnerships. All of this can be reflected in responsive policy and regulations. When Maryland received the Transformation grant, leadership developed a methodical strategy for implementation. Transformation selected projects that were ready to be implemented, had a plan for sustainability, and reflected MHA's value set. All projects were selected because they would produce lasting and sustainable changes in Maryland's public mental health system. Initiatives that at first seemed unrelated, have now been knitted together to form a system that is consumer-driven and recovery and resiliency based. Maryland has developed a three pronged approach to sustaining the momentum of Transformation: 1) Projects were staffed with individuals/agencies who could serve as champions beyond the life of the grant; 2) Recovery principles were embedded into every aspect of the mental health system; and 3) Training and technical assistance built the State's knowledge base and the number of available experts increased.

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Maryland's transformation efforts are recognized nationwide. The state was one of only six to be awarded a grade of "B" – the highest rating given in the National Alliance on Mental Illness' (NAMI) *Grading the States 2009* reports. In its report, NAMI recognizes Transformation as an innovative program. NAMI officials note that Maryland is a national leader in several areas, including support of consumer empowerment, collaboration with consumer and advocacy organizations, and in its wellness and recovery approach to mental health services. The Transformation Program has played a significant role in developing these efforts. In FY 2010, the final year of the transformation grant, our goal was to identify and achieve sustainability for innovative programs.

Partners in Recovery and Resilience

The strength of Maryland's PMHS comes mainly from its long-term, well-organized, and effective consumer, family, advocacy, and provider organizations. MHA has partnered with these organizations since their inceptions and, in fact, fostered their development. Additionally, MHA's partnerships include academic institutions and federal, state, and local agencies. MHA, in collaboration with local mental health authorities known as core service agencies (CSAs), manages the PMHS. Mental health transformation efforts and activities are infused throughout the MHA State Mental Health Plan for children, youth, and adults. The Plan includes numerous strategies to further strengthen consumer and family leadership and the promotion of a coordinated and efficient system that supports recovery and resilience across the life span.

MHA, in collaboration with the Mental Health Transformation Office (MHTO) and On Our Own of Maryland (OOOMD), will continue statewide implementation and operation of the Wellness and Recovery Action Plan (WRAP) training as part of ongoing efforts to increase the wellness and recovery orientation, enhance peer support activities, utilize best practices within the consumer movement, and begin to incorporate WRAP within community mental health programs. The Plan also addresses our increasing efforts to actively involve consumers and families in quality improvement and evaluation activities.

Throughout this Community Mental Health Block Grant Application in presenting the five mandated Criteria for both Adults and Children, Maryland's strengths and initiatives can be organized and highlighted in four categories:

Community Outcomes-

- Implementation of the Mental Health First Aid (MHFA) Program;
Implementation of Network of Care (NOC)
- Cultural Competence Initiative
- Consumer and Family Driven Social Marketing to support community recovery and resilience
- Utilization of State regulatory authority to set forth the expectation of movement towards a community that supports recovery

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- Development of centralized capacity for data mining and analysis

Child Well Being Outcomes-

- Build and strengthen infrastructure to support expansion of high fidelity wraparound services
- Continue Wraparound and System of Care (SOC) Training and coaching to ensure high fidelity
- Continue implementation of Youth MOVE statewide
- Promote family leadership and involvement in care
- Employ and retain quality mental health workforce
- Build infrastructure to support improved quality mental health care
- Establish a System of Care (SOC) for Transition-age Youth (TAY)

Adult Recovery and Resiliency Outcomes-

- Facilitate adult consumer and family member involvement in policy making, program planning, quality monitoring, and program evaluation activities
- Provide education on health and mental wellness that will allow consumers to attain recovery through a proactive response to triggers and health issues and adoption of a healthy lifestyle
- Strengthen and support the movement towards adoption of evidence-based practices (EBPs) in adult mental health services delivery
- Examine employment options and housing services to increase the mental health system workforce and consumer housing choices
- Develop technology to Support Recovery and Resilience.

Older Adult Recovery and Resiliency Outcomes-

- Facilitate older adult consumer and their family members' involvement in policy making, program planning, quality monitoring, and program evaluation activities.
- Build an infrastructure that supports the development and implementation of a statewide initiative to improve mental health services delivery systems to older adults and their families.

At this year's 2010 National Mental Health Block Grant and Data Infrastructure Grant Conference, Maryland's Chief of Evidence Based Practices and Program Evaluation presented on "Successful Supported Employment Programs in the States". MHA has developed, over the past several years, a successful approach to the implementation of evidence-based practices. Collaboration with the University of Maryland in supported employment, assertive community treatment, and family psycho-education, has helped identify both supports for and barriers, to implementation. This collaboration has also strengthened the supports, resolved the barriers and developed

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policy and financing for statewide implementation of these practices. MHA's relationship with the state Division of Rehabilitation Services (DORS) is an example of Maryland's collaborative strengths and commitment to supported employment. Outstanding integration between MHA and DORS at the state level and among CSAs, programs, and local DORS offices, has been recognized as exceptional by national leaders in implementation of evidence-based practices.

MHA has long promoted the concept of supported housing and consumer choice in housing and has developed policies and programs that reflect this commitment. Rates in the fee-for-service system help to support individuals' abilities to live in their own homes. Priority for community bond (capital) financing is given to development of affordable housing projects. Excellent interagency collaboration with the Department of Housing and Community Development (DHCD) has resulted in increased housing options for consumers of mental health services. Active work with local public housing authorities helps secure access to and stability in housing for consumers.

The PMHS continues to improve access to services. Using technology to improve access to mental health services, MHA launched a Web-based resource site, Network of Care (NOC) for Behavioral Health, which provides local, state, and national information to help consumers and families access services and manage their mental illness. Maryland was the first state to implement the NOC Website for veterans. This is a signature effort for the Lieutenant Governor and was highlighted in his Memorial Day communications throughout the state.

UNMET SERVICE NEEDS AND CRITICAL GAPS WITHIN THE CURRENT SYSTEM; (including identification of data sources used to identify the needs and gaps)

There are several sources of data which the MHA uses to identify unmet service needs and gaps. The ASO data systems combine MA eligibility, service authorization, and claims payment data into a rich, multi-variable database. A multitude of reports including consumer characteristics, service utilization, and expenditures can be generated. Special state reports on individuals with co-occurring illness show that they consume a disproportionate share of PMHS resources. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability.

There is general consensus that the benefit package in the PMHS is more comprehensive than the limited mental health services provided under many private health insurance plans; however, there are concerns among all stakeholders that maintaining access to services at this time of national and state economic crisis will be challenging. The issues raised are about the number or location of service programs, as well as the availability of highly specialized treatment services. Recent discussions have centered on continuous improvement in the quality of services; assuring that services are effective, recovery focused, and consumer driven; and that those most in need are able to

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receive the services. Coordination of care between somatic and psychiatric sectors remains critical, and has been made evermore pressing by the publication of new reports on the morbidity and mortality of individuals with serious mental illnesses (SMI). Several strategies in the State Plan focus on the need to coordinate care between providers in the public mental health system and primary care providers in the managed care organizations responsible for the management of the primary health and mental health needs of individuals.

Housing

A housing initiative has been launched with the support and technical assistance of the Technical Assistance Collaborative (TAC). In October 2008, TAC submitted a detailed, draft report entitled, “Transforming Housing and Services for People with Serious Mental Illness in Maryland.” A revised report was submitted in October 2009. The document includes three major components:

- A complete inventory and analysis of the existing residential program resources available to priority consumers under the auspices of the Department of Health and Mental Hygiene in Maryland
- An inventory of programs in the Maryland Department of Housing and Community Development (DHCD) that serve the needs of mental health consumers, including Low Income Tax Credits, Tenant-Based Programs, the Bridge Subsidy Program, and Shelter Plus Care.
- An analysis of the incentives and effects of the current system of residential services and the formulation of recommendations to: (a) improve the consumer-focused recovery outcomes of that system, and (b) explore opportunities to expand access to permanent supportive housing on behalf of priority consumers.

In crafting their report, TAC collected and reviewed numerous documents and statistical reports. They interviewed MHA, and housing officials and CSA, PRP and RRP staff as well as designated housing providers, consumer organizations, and hospital liaisons. TAC’s analysis found that on average, Maryland rents for one bedroom and efficiency units are much higher than a consumer’s entire monthly SSI income. Consumers receiving SSI would need to pay 149.5% of their entire monthly income to rent a one bedroom unit priced at the HUD Fair Market Rent. Efficiency units would cost 131.2% of monthly SSI income. Consumers on SSI are being “priced out” of housing. The report proposed that Maryland use House Bill 231, signed into law by the governor in April 2008, as a platform for a future rental assistance initiative if funding can be identified. Additionally, the TAC report included four specific Recommendations for Action: 1) A Bold Approach: 500 New Units of Tenant-Based Rental Assistance; 2) Improving Outcomes from the Capital Grant Program (DHMH Community Bond Program); 3) Improving Outcomes from DHCD's Disability Set-Aside Policy; and 4) Position MHA/DHCD Relationship for New Section 811 and Trust Fund Legislation.

Project for Assistance in Transition from Homelessness (PATH) and Shelter Plus Care funds will be used to continue to meet the needs of homeless individuals and those

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coming from detention centers. This year, MHA will work with courts, detention centers, public safety, and correctional services to better address the mental health needs of individuals entering or exiting these systems, as well as the needs of individuals in MHA facilities who are court-involved and ready for discharge. Starting July 2009 MHA collaborated with the Developmental Disabilities Administration (DDA) to develop services for individuals with mental illness and developmental disabilities who are currently in state psychiatric hospitals and will be transitioned to more appropriate care settings.

Behavioral Workforce Development

The national economic crisis has raised unemployment rates for all people. Maryland consumers speaking at forums, focus groups, and conferences identify the desire and need to work as a critical issue on the path to recovery.

Maryland's Mental Health Transformation Office (MHTO) has been examining various options to address mental health workforce recruitment and retention issues as well as ways to increase consumer employment and housing services. Workforce development, Supported Employment (SE) and increased housing options provide Maryland residents with the opportunity to receive supportive services that are consumer driven, strengths-based and free of stigma. Achieving this goal involves developing a workforce pipeline for mental health providers and expanding peer support, working with the Technical Assistance Collaborative, Inc. (TAC), expansion of the Ticket to Work Program, and assisting the Main Street Housing program with database development.

In FY 2009, the Sar Levitan Center at Johns Hopkins University, in collaboration with MHA, MHTO, Community Behavioral Health Association, the Governor's Workforce Investment Board, local workforce investment boards, two community colleges, other state and local agencies, and consumers focused its work on workforce and workplace development issues. The Levitan team collaborated with a broad range of professionals including representatives from the provider community, professional boards, the workforce system, and higher education. The workgroup addressed several issues including two key areas:

- Improving and strengthening recruitment pipelines for new workers. Many of the barriers to effective recruitment in Maryland require legislative and regulatory remedies. Others require revisiting licensing board processes and policies including testing and credentialing.
- Examining staff development and training policies and practices. Quality, availability and accessibility of current training practices were considered, as well as the need for development of additional training tools such as on-line classes, webinars, and direct training classes. To address training issues, the workgroup agreed to form an Education/Community College sub-workgroup including representatives of Essex and Anne Arundel Community Colleges, providers, and the workforce system.

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Rural areas commonly identify difficulty in recruiting and retaining mental health professionals (particularly those who treat special needs populations) and accessing to specialized services/programming (i.e., treatment for sexual offenders). Recruitment and retention of qualified mental health professionals, direct care workers, and administrators within MHA and the many programs of the PMHS remain challenging. Particularly challenging is the recruitment of persons of diverse ethnic and racial groups to treat the increasingly diverse needs of PMHS consumers. Recruitment of emerging leaders for the PMHS reflects the dearth of younger people nationwide selecting public service for employment opportunities. The historically lower wages for human service workers in comparison to many other occupations make competing for employees challenging. Plans regularly identify workforce issues – compensation, recruitment, retention, and training – in the priority of agenda issues for major PMHS private provider organizations in Maryland’s transformation. (Maryland’s training initiatives and EBP development are discussed under the combined single Criterion 5 covering both the Adult and Child Plan).

Transportation

MHA obtains information through its network of CSAs, consumer, family, provider, and advocacy partners, in reports to the Maryland Advisory Council on Mental Hygiene, and in annual MHA staff review of the CSAs annual local mental health plans. The issues of need for improved local transportation, particularly in rural areas, are identified as a priority need and a consistent barrier to care. Maryland operates mobility transportation services in many jurisdictions. Local health departments offer transportation for Medicaid recipients and PMHS community providers provide van pool transportation for program participants. Maryland’s Association of Core Service Agencies and the local mental health advisory councils have developed statewide rankings of local CSA service needs and consumer priorities. Additionally, the Maryland Department of Disabilities increasingly assumes leadership for cross-agency efforts for adults and transition-age youth especially in the areas of transportation, employment, and housing.

Services for Co-occurring Disorders

The need for enhanced coordination of services to improve access for consumers with co-occurring disorders is identified in the strategies in the State Plan and in local CSA plans. Work will continue with CSAs and the state ADAA on developing integrated care for co-occurring disorders through a state action plan and through local initiatives. Efforts at implementing the Continuous, Comprehensive, Integrated Systems of Care (CCISC) model for co-occurring mental health and substance abuse disorders is intensifying at the local level. MHA, in collaboration with University of Maryland will continue to implement training initiatives for outpatient mental health clinics to improve services for individuals with co-occurring disorders. (See Criterion 1- Co-occurring Services).

THE STATE'S PRIORITIES AND PLANS TO ADDRESS UNMET NEEDS AND CRITICAL GAPS

As discussed previously, the FY 2011 State Mental Health Plan contains numerous strategies to address the aforementioned service needs and gaps. Many of these strategies have been under development for several years and will continue to move forward even in the current budget crisis. In Section III of this application, we will discuss all of the mandated federal mental health block grant criteria in greater detail. At the end of each Criterion we will list the state strategies/ block grant objectives for the coming year. These objectives are repeated as the action steps in the performance indicators listed in the appendix to the application and on the WebBGAS Indicators.

One of Maryland's priorities for the PMHS is the need to maintain continuity of services despite fiscal challenges. This year several state strategies address efforts to improve coordination of care in the PMHS. MHA will continue to strengthen the ongoing collaborative work among the ASO and managed care organizations (MCOs), as well as collaborate with the University of Maryland, School of Medicine, Department of Psychiatry, to research best practices in psychiatry to better address: the interplay of physical and psychiatric care on the total health of the individual; negative side effects of medication; and reduction of morbidity and mortality for adults with mental illnesses. In discussing priorities for the FY 2011 State Plan, MHA leadership identified the importance of strategies providing for collaboration with consumers, providers, and other mental health stakeholders to promote and implement the smoking cessation initiatives at all levels in the PMHS.

RECENT SIGNIFICANT ACHIEVEMENTS

Recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care;

Throughout this document the reader will find achievements that reflect Maryland's progress towards the development of a comprehensive community-based mental health system for adults. Maryland's Mental Health Transformation Grant reached the fifth year in its development processes and advanced the implementation of infrastructure to support key state initiatives. MHA was able to achieve significant progress in the advancement of important aspects of Maryland's consumer driven systems.

Consumer-directed, recovery-oriented projects were the most significant achievements for the PMHS. MHA is also proud of its continued achievement around the implementation of evidence-based practices. Following the national recognition of MHA's Supported Employment Program, one of MHA's Assertive Community Treatment Program sites, People Encouraging People, was awarded SAMHSA's Science to Service Award in 2009.

PMHS Monitoring and Evaluation

Several major Evaluation Services endeavors are discussed in Criterion 5, including MHA's Outcomes Measurement System (OMS); the Consumer Quality Team (CQT), which is funded in large part through this Federal Block Grant; the annual Consumer Perception of Care Survey; and evaluation projects and activities conducted through MHA's contract with the University of Maryland Systems Evaluation Center (SEC), which is also funded through this Federal Block Grant.

- Maryland's Outcomes Measurement System (OMS), in operation since September 2006, is the result of a collaborative relationship among MHA, the University of Maryland Systems Evaluation Center (SEC), and MHA's Administrative Services Organization (ASO). In FY 2010, there were several major accomplishments related to OMS: 1) the successful transition of the OMS processes to a new ASO vendor; 2) the continued development and refinement of analytical structures to begin to report client outcomes; 3) the provision of jurisdiction-specific OMS outcome data to the CSAs; and 4) the provision of program-specific OMS outcome data to providers that requested it.
- The Consumer Quality Team (CQT) initiative, funded in large part through this block grant and launched in FY 2007 through the Maryland Mental Health Association, was another significant evaluation project that was continued in FY 2010. During FY 2010, the CQT conducted 168 site visits to Psychiatric Rehabilitation Programs (PRPs) and inpatient facilities, interviewing approximately 1,000 consumers.

Finally, MHA contract's with the Systems Evaluation Center (SEC) within the University of Maryland, School of Medicine, Department of Psychiatry, Center for Mental Health Services Research, and the Mental Health Systems Improvement Collaborative (MHSIC) for a variety of PMHS evaluation projects and activities. The SEC was created to increase MHA's capacity for a methodical and systematic approach to measuring PMHS performance. Overall goals of the SEC are to design systems/program evaluation questions, methods, and studies; develop analytic structures for more advanced analysis of existing PMHS data; and identify cost-effective practices with positive outcomes for consumers.

FUTURE VISION

A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

MHA's plan for its comprehensive, community-based public mental health system is to create a transformed system of care providing excellent mental health services that are focused on consumer recovery which employs evidence-based and effective practices and is outcome driven. A consumer-centered system which offers a range of effective peer support services and promotes consumer-defined recovery and self-direction is envisioned. The system will offer choices and encourage movement towards independence, as identified by the consumer. In Maryland's future mental health system, use of evidence-based, state-of-the-art treatments will become the norm. The culture of the workplace will be transformed to accept and promote the most advanced treatments. Additionally, efforts to promote cultural competence and meet the needs of an increasingly diverse population are a critical component of the future vision. Continuing anti-stigma activities will create the environment where people are comfortable about obtaining mental health services and help treatment providers recognize their own behaviors which may contribute to the stigma of mental illness and impede the very recovery of the individuals they treat. To further these efforts, MHA organized its FY 2011 plan activities under the SAMHSA's 10 Strategic Initiatives.

Additionally, in preparation for National Health Care Reform, Maryland's Governor established a new Health Reform Coordinating Council, co-chaired by the Lt. Governor and the DHMH Secretary to oversee the state's implementation of federal changes. The Council will consider and analyze the many policy changes and implementation decisions the federal reform presents and make recommendations to the Governor on how best to expand access and improve quality while reducing costs.

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The MHA envisions a future in which:

- The PMHS has sufficient resources to provide access to all individuals with significant mental health needs regardless of Medicaid insurance and/or individuals who are uninsured
- Individuals take the lead identifying their individualized plan of care; and then get the care they need regardless of the setting in which they find themselves
- Care provided is appropriate and is consumer and family driven
- Evidence-based practices are implemented and the use and evaluation of promising practices are encouraged
- The workforce is trained and data is used to improve services' process and outcomes
- Opportunities for the best use of funding, including innovative, flexible options are explored and made available
- Services are continuously examined and redesigned to best support recovery and resiliency
- Public mental health services are well linked and coordinated with both substance abuse and somatic health services
- Mental health consumers reduce current high levels of morbidity and mortality to improved levels similar to their peers with similar socio-economic life situations
- Individuals with mental illness are achieving their goals and dreams and maximize their human potential

Child and Adolescent

IDENTIFICATION AND ANALYSIS OF SYSTEM STRENGTHS, NEEDS, AND PRIORITIES

Strengths and Needs of the Child and Adolescent Service System

Maryland's Child and Adolescent System continues to reflect a core set of key strengths that are solidly based in the values and guiding principles of the System of Care philosophy. These foundational strengths and partnerships include:

- **The Children's Cabinet** – An active interagency policy, planning, and decision making body that oversees a large number of innovative interagency projects through implementation of the Maryland Interagency Strategic Plan.
- **Partnership with Maryland's Families and Youth** – A relationship that includes a deep commitment to fully enfranchising the statewide network for families, the Maryland Coalition of Families for Children's Mental Health, and the statewide network for youth – Maryland Youth MOVE – in all activities undertaken within the Children's Cabinet sphere and developments in the MHA-funded continuum of care.
- **Maryland Child and Adolescent Mental Health Institute** – A project committed to improving quality of mental health care within MHA-funded service continuum through a MHA partnership among Maryland's youth and family organizations, the University of Maryland and Johns Hopkins University Schools of Medicine, focused on expanding and testing evidence-based and promising mental health practices in the field.
- **Maryland Blueprint Committee** – An extensive advisory group with numerous working groups that is active in charting the course for efforts to improve services offered by MHA and assuring the integration of these efforts into the broader efforts of the Children's Cabinet. This planning and oversight process is based in a comprehensive vision of developmentally appropriate service improvement from pre-natal care and infancy through the end of the transition – age youth period (approximately 25 years of age). The Blue Print process includes special focus on outreach, human resource development, and quality improvement for cultural minorities and other specialized sub-populations across this critical part of the life span.
- **"Children's Mental Health Matters"** – A significant social marketing effort designed to improve public information, reduce the stigmatization of youth with mental health conditions, and garner public support for innovative system development through a major public awareness campaign. This effort may in some ways be our greatest strength because it goes beyond limited mandates for service improvement while addressing deeper contextual issues requisite for lasting system change and better results. The campaign features a media partnership with local affiliates of major television networks, and involves Maryland's First Lady, Katie O'Malley, as Honorary Chair and Debbie Phelps, mother of Michael Phelps, Maryland's celebrated Olympic swimmer, as media

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spokeswoman. A major media blitz occurred during Children's Mental Health Week, May 2010, and will be continued in the upcoming year.

These core areas of organizational and partnership assets and the various more detailed strategic activities planned in the upcoming year will be presented throughout this section. As such, they represent an outline for themes that will be repeated in several subsequent sections.

A few major projects for the upcoming year deserve to be highlighted in this section on strengths. Description of these projects will be expanded throughout the plan. As a result these descriptions serve only as previews introducing material that will follow with greater detail.

- Ongoing implementation of the CMS-funded Psychiatric Residential Treatment Facility (PRTF) Demonstration Project, a 1915(c) Medicaid waiver that will offer community-based services such as family-to-family peer support, youth-to-youth peer support, respite care, and other unique services in innovative ways under an approach to care management rooted in High Fidelity Wraparound philosophy.
- Implementation of two SAMHSA System of Care grants, Maryland CARES & Rural Cares, both of which share a special focus on children and youth in foster care in Baltimore City and the nine counties that comprise Maryland's Eastern Shore. These grants also build on care management provided through High Fidelity Wraparound process.
- Monitoring of the Children's Cabinet contracts for care management systems through three regional Care Management Entities for a number of specially identified populations. These populations include youth enrolled in the PRTF 1915(c) waiver, and the Maryland Cares/ Rural Cares system of care grant projects noted above, as well as all youth in child welfare and juvenile justice-funded group residential facilities.
- Implementation of Maryland's CMS funded "CHIPRA Quality Demonstration Project" around CME Implementation and the development of a three state Learning Collaborative with Georgia and Wyoming.

Identification of service needs and critical gaps

One of the greatest needs in the child and adolescent service sector is the lack of adequate mental health coverage for families served in the private insurance sector. This problem is extenuated by the fact that many of these families receive educational services under the provision of IDEA entitlement. The resulting disconnect often makes it difficult to develop the interagency system of care since free and appropriate education is considered a broad entitlement while publicly-funded health coverage is largely driven by financial eligibility. In addition, access to services for the uninsured remains a major issue for the state. This is a greater problem in the adult service sector than in the child and adolescent service system. The 1915(c) Medicaid waiver will begin to provide some small solutions to this problem as the waiver will provide an opportunity for some underinsured and uninsured families to receive Medicaid benefit services and specialized waiver services previously not available to them.

Despite extensive child and adolescent human resource development initiatives, described later in the plan, recruitment and retention of qualified mental health professionals and direct care workers within many programs of the child and adolescent system remains challenging. Particularly challenging is the recruitment of persons of diverse ethnic and racial groups to treat the increasingly diverse needs of PMHS consumers. The historically lower wages for human service workers compared with many other occupations makes competing for employees challenging. It should be noted that this problem is particularly acute in the non-professional work force where child care workers and other paraprofessionals are reimbursed at levels that are comparable to rates paid by fast food venues and other service jobs in the economy. Maryland has made strides in creating certification standards for residential child care workers and has established a pilot certificate program in partnership with a number of community colleges across the state to provide relevant training experiences and the possibility of a career ladder for these workers. Likewise, mental health professionals do not always receive training in evidence-based and effective practices. Training staff to deliver evidence-based practices (EBPs) is highly resource-intensive and current rate structures do not adequately support their implementation.

There is an uneven geographic distribution of qualified providers and provider types in the various jurisdictions of the state. For example, the availability of qualified child psychiatrists, particularly in rural areas, has been a long standing intractable problem. Overall access to specialty mental health services and tendency to adapt models of care developed specifically for urban settings can be a challenge in rural communities. Much of the recent system development activity in Maryland is based upon developing demonstration projects supported by grant funding. While this approach allows the state to focus on areas of greatest need and those service rich environments deemed ready to support a competitive demonstration, the approach contributes to widening disparities of service availability among the jurisdictions as a whole. This raises the problem of equity in service access. Maryland's system of CSAs helps the PMHS maintain a focus on services and needs in the rural and non-urban counties. Family members and advocates continue to identify the need for assuring a minimum core set of specialty services

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available in each jurisdiction, but this is a difficult problem to address in the context of resource reduction and financial challenge. A section on needs would not be complete without reference to the fiscal condition of the state. Interagency partners have sustained budget reductions in a number of areas, including a 3.5 Million dollar cut in the Governor's office for Children fund for Wraparound service delivery and a scaling back of the anticipated expansion of crisis services for foster children statewide described in last year's plan. As a result of these and other actions, our needs continue to expand through a process of attrition.

UNMET NEEDS AND CRITICAL GAPS WITH SOURCES OF SUPPORTING DATA

There are a number of needs/gaps that emerge from analysis of child and adolescent data sources:

- CSAs identified the statewide need for additional services to conduct Wraparound plans with children and adolescents. This need was identified locally as the General Assembly simultaneously reduced some funds in the Governor's Office for Children's budget in the past two years to conduct these kinds of services. The PRTF demonstration will offset some of these budget reductions. This need highlights one of the key gaps in Maryland's system.
- There is a need for alternative financing arrangements which would provide incentives for the development of home and community-based services instead of residential services. This gap will also be addressed for a small number of children through the PRTF Demonstration Project.
- Existing programs geared to meet the needs of transition-age youth remain at capacity and no expansion has been possible for the last few years. The need for services to support transition-age youth who are being discharged from residential treatment centers has been identified. Evidence-based practices for transition-age youth are limited but need to be explored and implemented as possible.
- Expansion of crisis response capability into jurisdictions statewide is consistently identified as an area of unmet need. Even though the Joint Council has advocated in this area and the crisis systems which exist are highly valued, replication of such systems, particularly for rural areas, is limited.
- Workforce development, particularly specialty trained mental health professionals and specialty programs, are also identified as needs. Of particular need in the child and adolescent system are treatment foster care parents and provider organizations which support them in delivering the service. Providers and programs proficient in working with co-occurring mental illness and substance abuse, as well as mental illness and developmental disabilities, are limited and the need far exceeds availability.
- Finally, rural areas commonly identify transportation, difficulty in recruiting mental health professionals, particularly those who treat special populations, access to specialized services/programming (i.e., child psychiatry, treatment for juvenile sexual offenders), and lack of crisis response capacity as significant gaps.

PRIORITIES/PLANS TO ADDRESS UNMET NEEDS

MHA and the mental health stakeholder community will continue to voice the need for attention to mental health care in budget considerations. However, the projections for upcoming budget periods are not encouraging with regard to state revenues and the corresponding impact that they have on reduction of spending. Continued vigilance will be necessary as the state prepares to address its long-term structural deficit and as scenarios for managing this ongoing fiscal crisis are proposed, debated, and enacted. As a consequence, a number of priorities come to the fore:

- A major priority to address those needs connected to the broader financial needs of the State budget will be continuation of the Children's Mental Health Matters Campaign and activities designed to bolster public support for recognizing the importance of and the need to protect children's mental health programs.
- Additional priorities are found in the ongoing implementation of federally funded special projects such as the PRTF Demonstration Waiver, which will allow federal matching dollars for innovative services and care management functions and administrative costs that are currently funded only by the state. Similarly, implementation of SAMHSA funded demonstration projects such as the Maryland CARES System of Care grant and Linkages to Life Statewide Suicide Prevention grant are very important priorities. It is important to note the role that these federally funded programs play in offsetting the contraction of state revenues and its impact on staff morale through maintaining a sense of strength based growth and forward progress within the child and adolescent system.
- A significant priority is placed on the interagency development of Care Management Entities, which blend federal and state dollars across a variety of fund sources to achieve great efficiencies with our sister agencies in the context of this period of fiscal austerity. This development is subject to continued availability of funds needed to contract under the current open RFP.
- Quality of care issues remain a critical point of focus, with emphasis on improving the services that MHA delivers through its continuum. Even with increasingly scarce resources, these services will continue to be enhanced both by strengthening approaches through training of the work force, and by investigating and assuring that minimum standards of care are met within existing programs. The Child and Adolescent Division stands strongly with the rest of MHA in concerted priority efforts to root out fraud and abuse within a small fraction of the existing provider network in order to assure quality.

RECENT SIGNIFICANT ACHIEVEMENTS

Our most significant achievements in the past year have been highlighted in the previous Strengths section. These include Children's Mental Health Matters, the award of two major federal grants, innovative services planned under the PRTF waiver, the Children's Cabinet Interagency Strategic Plan, the Maryland Child and Adolescent Mental Health Institute and the Children's Cabinet release of an RFP for statewide implementation of Care Management Entities to be implemented next year.

MHA, in collaboration with the Maryland Child and Adolescent Mental Health Institute, MSDE, the Center for Maternal and Child Health, the Maryland Blueprint Committee, and other stakeholders, continue to build infrastructure and deliver training to improve quality of mental health screening assessment and intervention for young children. Activities include:

- The University of Maryland Early Childhood Certificate program offered to Bachelor's level participants. An additional 36 professionals will be trained.
- Continued implementation of project with the Center on the Social and Emotional Foundations for early Learning (CSEFEL).

MHA will work in conjunction with Department of Human Resources (DHR) and other stakeholders to improve screening, assessment, and service delivery for children and youth in foster care. Projects include:

- Efforts with Baltimore City to strengthen the mental health component of the local DSS child welfare health suite for all youth entering foster care in Baltimore City to assure combined health and mental health screening
- Implementation of MD CARES and Rural CARES – Both comprehensive SAMHSA System of Care grants designed for foster care children in Baltimore City and Maryland's nine Eastern shore counties respectively
- Continued provision of the Crisis Response and Stabilization Service Initiative in selected jurisdictions, supported by specialized training for police and emergency services workers, for children placed in foster care settings
- Implementation of Maryland's CMS funded "CHIPRA Quality Demonstration Project" around CME Implementation and the development of a three state Learning Collaborative with Georgia and Wyoming
- Implementation, through the support of the SAMHSA Statewide Youth Suicide Prevention and Early Intervention grant "Maryland's Linkages to Life", of a diverse range of innovative statewide and local youth suicide prevention activities and training in evidence-based practices for suicide prevention /intervention such as:
 1. Development of local coalitions for implementation of prevention activities and training within local school systems
 2. Development of pilot projects for identified high risk rural counties and counties with large numbers of completed suicides

FUTURE VISION

MHA's plan for its comprehensive, community-based public mental health system is to create a System of Care that is focused on family and child resilience, which employs evidence-based and effective practices, and which is outcomes driven. A family-driven, youth-guided system of care that offers a range of effective treatment and youth and family support services is envisioned. The need for relinquishment of custody will be fully eliminated and the financing of the system will encourage the use of family-centered, home and community-based wraparound services, rather than institutional and residential care.

In Maryland's future mental health system, use of evidence-based, state-of-the-art treatments will become the norm. Information about evidence-based, effective, and emerging best practices will be disseminated to a wide base of PMHS providers and to families. The culture of the work place will be transformed to accept and provide the most advanced treatments. Additionally, efforts to promote cultural competence and meet the needs of an increasingly diverse population are a critical component of the future vision. Continuing anti-stigma activities will create the environment where families, children, and adolescents are comfortable about obtaining mental health services. Families will consistently share in decision-making about treatment and family/provider partnerships will be encouraged.

The MHA envisions a future in which:

- The PMHS has sufficient resources to provide access to all children, youth and families with significant mental health needs regardless of Medicaid insurance and/or individuals who are uninsured
- Care provided is appropriate and is youth and family driven
- Evidence-based practices are implemented and the use and evaluation of promising practices are encouraged
- The workforce is trained and data is used to improve services' process and outcomes
- Opportunities for the best use of funding, including innovative, flexible options are explored and made available
- Services are continuously examined and redesigned to best support recovery and resiliency
- Public Mental Health Services are well-linked and coordinated with both substance abuse and somatic health services
- Health and wellness are promoted to reduce the risk of morbidity and mortality later in life